AUDITOR
GENERAL
Alberta

Report of the Auditor General of Alberta

April 2008

ISSN 1703–7166

AUDITOR
GENERAL
Alberta

Chair
Standing Committee on Legislative Offices

I am honoured to send my semiannual report titled *Report of the Auditor General—April 2008* to the members of the Legislative Assembly, as required by section 20(1) of the *Auditor General Act*.

[Original signed by Fred J. Dunn, FCA]
Fred J. Dunn, FCA
Auditor General

Edmonton, Alberta
April 3, 2008

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Introduction

Summary of our key findings

Government restructuring

Government restructuring, announced on March 12, 2008, resulted in changed responsibilities and several new ministries. We report on the government ministries as they were on March 12, 2008, before the restructuring. However, we have made our recommendations to the ministries that will have to report to the Public Accounts Committee on their progress in implementing them.

Public Accounts Committee's response to our work

To maximize the value of our work, the Public Accounts Committee may wish to focus its efforts on the key findings summarized below. By discussing them with the relevant Deputy Ministers, the Committee can continue to effectively fulfill its role to keep government accountable for its spending of public money.

Our key findings

The government needs to take the following actions to improve its performance in providing services to Albertans effectively:

> **Clarify expectations and improve management of non-credit programs**—the Department of Advanced Education and Technology needs to clarify its standards and expectations for non-credit programs and clearly communicate them to public post-secondary institutions. See recommendation 1 on page 22. Similarly, the public post-secondary institutions need to improve their systems to measure and report the costs of providing non-credit programs, review and approve decisions to offer programs, and evaluate the quality of the programs. This will let management of these institutions make proper business decisions, such as which programs to offer and what price to charge. See Table 2 on page 20 for a summary of our findings on the six public post-secondary institutions we audited.
>
> **Implementing the *Provincial Mental Health Plan***—the Department of Health and Wellness and the Alberta Mental Health Board need to improve their systems to plan, monitor, and report on the implementation activities for the *Provincial Mental Health Plan*. This includes ensuring that the organizations implementing the *Plan* clearly understand their roles, responsibilities, and performance expectations—see recommendations numbered 3 and 4 on pages 72 and 77. Without these systems, there is a risk that the *Plan* priorities may not be achieved and momentum for the implementation of the *Plan* may fade.

Improve compliance monitoring—the Departments of Health and Wellness and Seniors and Community Supports have developed new care and accommodation standards for long-term care facilities and supportive-living settings. The Departments and Regional Health Authorities have developed systems to monitor compliance with the new standards, but further work is required—see page 95 for the results of our work.

Identify and manage conflicts of interest—the Ministry of Transportation has an ineffective system to identify and manage conflicts of interest for employees and subcontractors of parties it contracts with. It needs to improve this system. The Ministry also needs to work with the Department of Justice to ensure its contracts have good provisions on conflicts of interest, including adequate disclosure requirements. Without these improvements, individuals performing services for the Ministry may make decisions based on personal interests rather than the interests of the Ministry, leading to inefficiencies and decreased value for money—see recommendations numbered 5 and 6 on page 155.

Manage Information Technology (IT) risks—Service Alberta needs to work with ministries and the CIO Council to better manage IT risks. They need to develop and promote an IT control framework—plus guidance on implementing it. Then, they need to develop and promote good and efficient IT control processes and activities—based on the framework. While all departments have IT control processes and activities to some extent, overall, no department has an adequately documented and effective IT control framework in place—see recommendation number 7 on page 170.

Public post-secondary institutions also need to better manage IT risks. Current practices in the institutions range from good IT controls that still need some improvements, to ineffective IT controls that require immediate work—see our summary of findings by institution starting on page 203. The Department of Advanced Education and Technology needs to give guidance to these institutions on using an IT control framework and developing control processes. Guidance is needed as not all institutions currently have the ability, resources, or knowledge to properly use a control framework or implement effective IT controls—see recommendation number 8 on page 195.

Without these improvements, Albertans' personal information, and the government's and public post-secondary institutions' financial information or systems could be inaccurate, unavailable in the event of a disaster, or improperly accessed, disclosed, or misused. Also, if the accuracy of financial information is impaired, it may result in wasted effort and cost in providing services to Albertans.

Acknowledgements

We are grateful to the Members of the Legislative Assembly, in particular the members of the Standing Committee on Public Accounts, who provide us with suggestions for audits they would find useful in doing their work as legislators. We appreciate their advice and thank them for their ongoing support.

We continue to appreciate input from members of the public who contact us to express concerns about government systems. They help us to plan the focus of our future audit work.

We thank the members of the Provincial Audit Committee for their wise counsel. This group of senior business executives with financial, business and governance skills has an important advisory role to government and the Office of the Auditor General.

We appreciate the cooperation of those we audit and recognize it is fundamental to our success. Senior management and board members of audited organizations met with us to discuss our audit plans, findings and recommendations. They provided us with the necessary information, reports, and explanations to our questions.

We acknowledge the advisors who helped us complete our major systems audits. We appreciate their valuable contributions to our audit teams and our work.

My staff, and the agent firms they work with, are dedicated to objective and cost-effective auditing for the Legislative Assembly and the people of Alberta. I thank them for their thorough and professional work.

[Original signed by Fred J. Dunn, FCA]
Fred J. Dunn, FCA
Auditor General

April 3, 2008

Recommendation highlights

Prioritizing our recommendations

Prioritizing recommendations to help MLAs

As part of the audit process, we provide recommendations to government in documents called management letters. We use our public reporting to bring our recommendations to the attention of Members of the Legislative Assembly (MLAs). Members of the all-party Standing Committee on Public Accounts refer to our recommendations during their meetings with representatives of government ministries and agencies. To help MLAs, we prioritize our recommendations in our public reports to indicate where we believe they should focus their attention. We categorize them as follows:

- **Key recommendations**—these are the recommendations we believe are the most significant. By implementing these recommendations, the government will significantly improve the safety and welfare of Albertans, the security and use of the province's resources, or the governance and ethics with which government operations are managed.
- **Numbered recommendations**—we believe these recommendations require a formal response from the government. We ask government to accept these recommendations and commit to an implementation plan and date.
- **Unnumbered recommendations**—these recommendations, although important, do not require a formal response from government. We obtain management's acceptance of these recommendations, and agree to an implementation plan and date.

New recommendations

This Report contains 17 new recommendations, all of which are listed beginning on page 9. We have numbered the 8 recommendations that we think need a formal response from the government.

Key recommendations

The key recommendations, in serial order, are numbered: 1, 3, 6 and 7.

List of outstanding recommendations

Outstanding recommendations

We provide a complete list of the recommendations that are not yet implemented in our Outstanding recommendations chapter—see page 221. Typically, we do not report on the progress of an outstanding recommendation until management has had sufficient time to implement the recommendation and we have completed our follow-up audit work.

We publish a list of recommendations more than three years old annually in our October public report—see *Annual Report 2006-2007*, vol. 2, page 218. Since the benefit of any audit work is not in the recommendation, but in its effective implementation, we follow up all of our recommendations until the issue that gave rise to the recommendation is satisfactorily dealt with.

Semiannual reporting

Semiannual public reporting

We report to the Legislative Assembly twice a year—April and October. Semiannual reporting allows us to report the results of our work sooner and in a predictable timeframe. We believe Albertans and the Standing Committee on Public Accounts benefit because information will be more current.

April 2008 recommendations

🗝 **Indicates a key recommendation**

Green print—other numbered recommendations

Black print—unnumbered recommendations

Systems audits

Advanced Education and Technology

Post-Secondary Institutions—non-credit programs

See page 22 **Clarify standards and expectations—Recommendation No. 1**

🗝 We recommend that the Department of Advanced Education and Technology:

- clarify its standards and expectations for non-credit programs and clearly communicate them to public post-secondary Institutions.
- work with Institutions to improve the consistency of information that Institutions report to the Department.

See page 23 **Monitor Institutions' non-credit programs—Recommendation No. 2**

We recommend that the Department of Advanced Education and Technology implement effective processes to:

- monitor whether Institutions report information consistent with its expectations.
- investigate and resolve cases where Institutions' program delivery is inconsistent with its standards and expectations.

See Appendix A—Post-Secondary Institutions—non-credit programs recommendations, made to management, on page 31.

Monitoring vocational programs and degrees offered by private institutions

See page 42 **Monitoring vocational programs offered by private institutions—Recommendation**

We recommend that the Department of Advanced Education and Technology:

- develop a risk-based strategic audit plan of new and follow-up audits, including timelines and resources to audit private institutions.
- issue Orders and information on deficiencies within a reasonable time after completing the audit.

Northern Alberta Institute of Technology—construction management processes

See page 48 **Northern Alberta Institute of Technology—selection processes—Recommendation**

We recommend that the Northern Alberta Institute of Technology:

- include conflict-of-interest provisions in construction-management contracts.
- improve its sole-sourcing policy to require, where appropriate, adequate documentation of justification and approval for construction-contract work that is sole-sourced.

Energy

Department of Energy's system for identifying and managing conflicts of interest

See page 57

Energy—Documenting potential conflicts of interest—Recommendation
We recommend that the Department of Energy follow its own policies and processes by ensuring discussions, conclusions, and actions taken—including the risk-mitigation strategy—when an employee has declared a potential conflict of interest are clearly documented and retained.

Health and Wellness

Implementing the Provincial Mental Health Plan

See page 72 🔑

Implementation systems—Recommendation No. 3
We recommend that the Alberta Mental Health Board and the Department of Health and Wellness, working with other mental health participants, strengthen implementation of the *Provincial Mental Health Plan* by improving:

- implementation planning,
- the monitoring and reporting of implementation activities against implementation plans, and
- the system to adjust the Plan and implementation initiatives in response to changing circumstances.

See page 77

The accountability framework—Recommendation No. 4
We recommend that the Department of Health and Wellness ensure there is a complete accountability framework for the Provincial Mental Health Plan and mental health services in Alberta.

Transportation

Identifying and managing conflicts of interest for contracted IT professionals

See page 155

Identifying and managing conflicts of interest for contracted IT professionals—Recommendation No. 5
We recommend that the Ministry of Transportation, in consultation with the Department of Justice, review and revise contracts for IT professionals, ensuring that there are adequate conflict-of-interest provisions with accompanying disclosure requirements.

See page 155 🔑

Identifying and managing conflicts of interest for contracted IT professionals—Recommendation No. 6
We recommend that the Ministry of Transportation improve its system for identifying and managing apparent or real conflicts of interest for contracted IT professionals.

Service Alberta

IT Control framework

See page 170 🔑 **Guidance to implement IT control frameworks—Recommendation No. 7**
We recommend that the Ministry of Service Alberta, in conjunction with all ministries and through CIO Council, develop and promote:

- a comprehensive IT control framework, and accompanying implementation guidance, and
- well-designed and cost-effective IT control processes and activities.

Financial statement and other assurance audits

Advanced Education and Technology

See page 180 **Alberta College of Art and Design—Financial reporting and year-end processes—Recommendation**
We recommend that Alberta College of Art and Design improve its processes and internal controls to increase efficiency, completeness, and accuracy in financial reporting.

See page 182 **Alberta College of Art and Design—Payroll controls—Recommendation**
We recommend that Alberta College of Art and Design improve its payroll controls by properly segregating payroll processing duties and implementing controls for processing manual cheques.

See page 183 **Grande Prairie Regional College—Financial reporting and year-end processes—Recommendation repeated**
We again recommend that Grande Prairie Regional College improve its processes and controls over financial reporting to increase efficiency in preparing accurate internal and external financial reports.

See page 184 **Grande Prairie Regional College—Capital asset management—Recommendation**
We recommend that Grande Prairie Regional College improve its processes and controls over capital assets.

See page 186 **Grant MacEwan College—Bookstore operations—Recommendation**
We recommend that Grant MacEwan College improve its systems to:

- manage and report inventories
- monitor and account for the use of petty cash

See page 189 **Portage College—Fuel purchases on fuel cards—Recommendation**
We recommend that Portage College develop guidelines and procedures for review and approval of fuel purchases on fuel-purchase cards.

College and technical institute computer controls

See page 195 **Well-designed and effective IT control policies and processes—Recommendation No. 8**
We recommend that the Department of Advanced Education and Technology give guidance to public post-secondary Institutions on using an IT control framework to develop control processes that are well-designed, efficient, and effective.

See Appendix A—Post-secondary institution recommendations, made to management, on page 203.

Systems audits

Post-Secondary Institutions—non-credit programs

1. Summary

Department funds credit programs

Public post-secondary Institutions primarily offer credit programs (degree and diploma programs) funded by grants from the Department of Advanced Education and Technology and student tuition fees.

Non-credit programs not funded by Department

During the 1990s, the Department encouraged Institutions to become more entrepreneurial to raise funds for Institutions, so Institutions also offer non-credit programs to the public and organizations. The Department does not fund these programs. Usually these programs aim for a profit, but not always. Sometimes these programs have other qualitative benefits. For example, some programs benefit the community. In 2006–2007, the Department systems reported, based on submissions by the 20 Institutions in Alberta, revenues of $134 million for delivering non-credit programs, which exceeded direct costs by $12 million (2005–2006—$10.3 million; 2004–2005—$10 million).

We also provide the total net losses that Institutions reported to the Department to give context to the issues we raise in this report. These losses are based on full costs, including some costs that Institutions would incur even if the non-credit programs did not take place (for example, certain facility costs), and some incremental overhead costs that Institutions incur to deliver non-credit programs (for example, extra staff needed to process student registrations). When considering overhead costs, in 2006–2007, the Department's systems reported, based on submissions from the 20 Institutions in Alberta, net losses of approximately $58 million delivering non-credit programs (2005–2006 net loss-$49 million; 2004–2005 net loss-$42 million). The Department does not know if, in fact, these non-credit programs are producing profits or losses in aggregate, when all incremental costs are included. Because of the issues we raise in this report, the Department and Institutions are unable to conclude the net losses number is accurate, how much of the net losses, if any, are due to incremental overhead costs of delivering non-credit programs, and how much of the net losses are due to providing other qualitative benefits.

Department

We examined if the Department has effective systems to monitor Institutions' non-credit programs. We concluded that the Department has systems, but can significantly improve them by:

- clarifying expectations for non-credit programs and clearly communicating them to Institutions.

- working with Institutions to improve consistency in reporting financial results.
- monitoring whether Institutions meet the Department's expectations and resolving cases where they do not.

Unclear expectations, overhead cost discrepancies, and no follow-up

Because Institutions are unclear on the Department's expectations for non-credit programs, they include different overhead costs, and allocate overhead costs inconsistently in financial reports to the Department. Overhead costs reported vary greatly (2006–2007—from 13% to 641% of direct costs). The Department identifies issues in the financial reports of the various Institutions and communicates them, but it does not follow up to ensure Institutions revise the numbers. Nor does it ensure the revisions are in the final summary financial reports available to the Institutions. This limits the usefulness of the reports for making comparisons between Institutions, both for the Department and Institutions. Also, without good information to demonstrate that non-credit programs are recovering incremental overhead costs not approved by the Department, Department grants may support programs not approved by government.

Institutions

We sampled 6 of the 20 public Institutions to examine if they have effective systems to manage non-credit programs and their risks.

Good decisions need good information

Institutions' management and Boards need to have good information on both costs and objectives of non-credit programs. This will let the Institutions make proper business decisions, such as which programs to offer and what price to charge.

Varying degrees of improvements required

We concluded that all 6 Institutions can improve their systems to manage non-credit programs; some need greater improvement than others. Some, for example NAIT, generally had good systems; others, for example Grande Prairie Regional College, had systems that need significant improvements. This report summarizes the findings. Our recommendations to the 6 Institutions are in the appendix.

Overall, Institutions need to improve the systems to:

- measure the costs of delivering non-credit programs.
- review and approve decisions to provide or continue each non-credit program or course.
- report cost information to program coordinators, senior management and the Board.
- set measurable expectations and evaluate the quality of programs.

Examples of problems:
- not all costs considered
- courses with one student

We found, for example, Institutions that did not include all incremental overhead costs of providing a non-credit program in their analysis of whether to provide the course, or what to charge for it. The approval processes were not well defined, and the same person often initiated and approved a course. This resulted in courses proceeding with only a few students, and sometimes just one student, or without a signed contract.

2. Audit objectives and scope

2.1 Our audit objectives

We set out to answer the following questions:

- Does the Department have effective systems to monitor non-credit programs? Do the systems clearly communicate standards and expectations for non-credit programs, monitor Institutions' delivery of non-credit programs, and resolve problems?
- Do Institutions have effective systems to manage non-credit programs and their risks? Can management of Institutions assess if goals are met or changes are needed?

2.2 Our scope

We examined the:

- roles and responsibilities of the Department and Institutions
- Department systems to monitor Institutions' non-credit programs
- Institutions systems to initiate and manage their non-credit programs

We focused on continuing education programs, contracted training and other services without Department funding. We did not examine systems for ancillary operations such as bookstore, residences or food services.

Of the 20 public Post-secondary Institutions in Alberta, we examined the following Institutions' systems:

- Bow Valley College
- Grande Prairie Regional College
- Northern Alberta Institute of Technology (NAIT)
- Olds College
- Red Deer College
- Southern Alberta Institute of Technology (SAIT)

3. Overview of non-credit programs

3.1 Role of Department of Advanced Education and Technology

The Department is responsible for:

- communicating to Institutions its expectations for recovery of costs.
- monitoring if Institutions are effectively managing their non-credit programs and delivering them consistently with their approved mandate and other Ministry standards and expectations.

- investigating problems, providing direction, and taking action to ensure problems are resolved.

Department reviews Institutions' financial results in central system

Institutions report their annual financial results (revenue and expenses) in the Department's Financial Information Reporting System (FIRS) by different classifications such as credit and non-credit programs. Institutions' senior financial officers approve the information sent to the Department. The Department instructs Institution staff how to classify revenues and expenses through a reporting manual. The manual tells Institutions to directly attribute overhead costs to different categories, when possible. Otherwise, Institutions can use a recommended allocation method or choose a different one. Institutions can compare their results in FIRS against results of other Institutions.

3.2 Mandates and roles of Institutions

Department and tuition fees fund credit programs

Institutions primarily offer degree and diploma programs that the Minister of Advanced Education and Technology approves under the *Approval of Programs of Study Regulation.* These are called *credit programs* and are funded by Department grants and student tuition fees.

No grants for non-credit programs that include:

Institutions also offer non-credit programs to the public and organizations. The Minister is not required to approve these programs under the *Approval of Programs of Study Regulation.* They are called cost-recovery or *non-credit programs,* as the Department does not provide grants to Institutions for them. Non-credit programs include:

- Continuing education programs
- continuing-education programs and courses to the public that allow students to update their skills. Institutions deliver these programs on campus but sometimes at other locations or through distance learning.
- Contract training
- programs or services to organizations, both public and private, on a contract basis. This includes continuing education programs or customized training courses to meet organizations' needs. Sometimes, it gives Institutions qualitative benefits. For example, instructors may access new technologies or students may gain practical experience, improving the Institution's credit courses.
- Partnerships with foreign Institutions
- partnerships or arrangements with foreign institutions to provide programs or courses to foreign students or to attract foreign students. Countries covered by the six Institutions we audited include China, Mexico, United Arab Emirates, and Kazakhstan. Institutions must consider different cultures, business practices, legal and tax systems.
- Programs to benefit community
- programs or services such as music programs and camps that may benefit the community. These programs often use Institutions' facilities such as theatres and conservatories.

Centralized to decentralized structures

The organizational structure for administering non-credit programs in Institutions ranges from centralized to decentralized. Program coordinators in a central department or different academic departments often initiate, review and approve, monitor and report on non-credit programs.

Some services outsourced

Some Institutions contract with third parties to deliver non-credit programs. For example, SAIT uses a third party to administer some of its continuing education programs, while Grande Prairie Regional College uses a third party to deliver its *Be Fit for Life Program*.

3.3 Costs to consider in offering non-credit programs

Accurate cost information needed to manage non-credit programs

To know what to charge for non-credit programs, Institutions need complete and accurate information on the costs of these programs, including:

- direct costs—for instructors, books, supplies and materials.
- overhead costs—these consist of:
    - incremental overhead costs—for direct administration, such as salaries for program coordinators and administrative staff, and additional overhead costs as a result of more non-credit programs and students. For example, Institutions may need to hire more staff in the registrar's office to deal with more students, transactions, and activities.
    - fixed overhead costs—these do not change just because Institutions offer non-credit programs. For example, a non-credit program does not affect the need for a roof replacement.

Incremental overhead costs important

Institutions must decide on the appropriate level of detail for decision-making, but just ignoring incremental overhead costs is not a reasonable option. Especially in the short term, some overhead costs are fixed or sunk costs. Institutions may decide to use excess capacity to help defray fixed overhead costs. But in the long term, many overhead costs represent opportunity costs. Institutions may decide to no longer offer certain non-credit programs, and instead use facilities and other resources for other purposes, such as to:

- offer credit programs or other more productive non-credit programs.
- offer facilities for short-term leases to private and public organizations that seek instructional space.
- expand educational support services (e.g. more library space).

4. Conclusions

We developed five criteria (which management agreed with) to assess performance of the Department and Institutions—two for the Department and three for Institutions. Here are the criteria and Department and Institution results in meeting them:

Table 1—Department's results in meeting criteria

	Criteria	Conclusion			
		Met	Partly met	Not met	Related recommendation
4.1	Clearly communicate expectations for non-credit programs.		√		5.1
4.2	Monitor and evaluate Institutions' delivery of non-credit programs.		√		5.2

Department should:

- Clarify what costs to recover

4.1 Clearly communicate expectations for non-credit programs

The Department partly met the criteria. It clearly communicated to Institutions the programs it funds. Institutions know they have to recover costs of programs not funded by Department grants. But the Department has not clearly specified which overhead costs to recover or how to ensure Institutions' information is comparable. See Section 5.1.

- Follow up monitoring issues

4.2 Monitor and evaluate Institutions' delivery of non-credit programs

The Department partly met the criteria. Department staff inform Institutions of potential issues with information they submit through the Financial Information Reporting Systems. But the Department has not used these tools effectively to monitor Institutions' non-credit programs. Nor has it asked Institutions to report on issues raised in its analysis of their financial information, or obtain revised information. See section 5.2.

Table 2—Institutions' results in meeting criteria

	Criteria	Bow Valley	Grande Prairie	NAIT	Olds	Red Deer	SAIT	Related findings
4.3	Establish and communicate policies, standards and expectations for non-credit programs	Partly met	Partly met	Met	Partly met	Partly met	Partly met	5.3
4.4	Initiate and approve non-credit programs	Partly met	Not met	Partly met	Partly met	Partly met	Partly met	5.4
4.5	Monitor and evaluate non-credit programs and report results	Partly met	Not met	Met	Partly met	Met	Partly met	5.5

Institutions should:

- Assess expectations using actual data

4.3 Establish and communicate standards or expectations

Staff generally understood their Institutions' pricing guidelines by charging course attendees an additional 15% to 50% of direct costs to cover overhead costs of non-credit programs. However, Institutions have not clearly defined (in policies and guidelines) their expectations for profit, or community and other benefits. Nor have they recently reviewed, analysed, or used the financial information they report to the Department to assess if their pricing guidelines are reasonable. In addition, many Institutions do not have adequate procedure manuals, and staff do not receive formal training. See section 5.3.

- Improve assessment and approval processes

4.4 Initiate and approve non-credit programs

Generally, Institutions have processes to initiate non-credit programs, but lack adequate segregation of duties between the people who initiate, approve and monitor non-credit programs. As a result, we found inadequate support and approval for some programs where Institutions did not recover incremental overhead costs or recovered less than expected. Also, Institutions often did not document business and legal risk assessments, and often did not set minimum enrolment requirements. No contracts existed to provide some programs to organizations; for others, contracts were signed after services started. See section 5.4.

- Improve reporting of cost information and analysis of student evaluations

4.5 Monitor and evaluate non-credit programs and report results

Institutions record the direct costs for non-credit programs in their financial systems and report results to management and Boards. But most Institutions do not include all incremental overhead costs in their reporting and analysis. Although Institutions monitor financial results of third parties who deliver non-credit programs, they do not adequately monitor non-financial performance of third parties, such as whether students' training needs are met. As well, Institutions often do not set measurable outcomes or expectations, and do not systematically analyse, review and report student course evaluations. See section 5.5.

5. Findings and recommendations

Sections 5.1 and 5.2 are our findings on, and recommendations to, the Department. Sections 5.3 to 5.5 summarize our findings related to Institutions. We reported the detailed findings and recommendations to management of each Institution separately. See Appendix A for the recommendations to Institutions.

5.1 Clarify standards and expectations

Recommendation No. 1

We recommend that the Department of Advanced Education and Technology:

- **clarify its standards and expectations for non-credit programs and clearly communicate them to public post-secondary Institutions.**
- **work with Institutions to improve the consistency of information that Institutions report to the Department.**

Background

No grants to be used for non-credit programs

The Department does not provide grants for Institutions' non-credit programs. Operating grant letters from the Minister direct Institutions to use operating grants to "support the delivery of approved credit instruction," and say, "delivery of non-credit programs and ancillary services should be done on a cost-recovery basis."

Criteria: the standards we used for our audit

The Department should establish expectations for Institutions' delivery of non-credit programs.

Our audit findings

Expectations communicated long ago, unclear and hard to find

The Department provided written communication of its overhead cost recovery expectations for non-credit programs to Institutions more than 10 years ago. We have not been able to locate this guidance. Department staff told us that they more recently communicated verbally that the Department expects Institutions to recover, at a minimum, their direct costs for non-credit programs. The Department recently drafted a document defining various categories of costs and shared it with Institutions. But the definitions do not properly define fixed and incremental overhead costs. As a result, Institutions' senior management, and staff managing non-credit programs, are unclear on the Department's expectations of which costs to recover. Institutions' management expects non-credit programs to recover both direct costs and some or all incremental overhead costs.

Inconsistencies between Minister's letter and verbal communication

The Department's recent verbal communication that Institutions recover only direct costs appears inconsistent with the Minister's direction in the grant letters. If institutions need to recover only direct costs, it implies they may use grants for incremental overhead costs of non-credit programs. If the Department intends to fund overhead costs of non-credit programs, it should explicitly say so, detailing what costs it will fund and define its objectives in doing so. And, the Department needs to review the FIRS reporting requirements, after it explains the expectations, because Institutions currently report an allocation of all overhead costs to non-credit programs.

Institutions allocate overhead costs in different ways

Institutions allocate overhead costs to non-credit programs using significantly different methodologies. Particularly, the allocated overhead expenses, as a percentage of direct expenses, ranged from 13% at Grande Prairie to 122% at SAIT in our audit sample, and from 13% to 641% for all 20 Institutions. These variations were consistent with previous years. In 2007, the Department hired a consulting firm to study program costing in 4 Institutions. The study confirmed the inconsistencies. The consultant recommended that the Department work with Institutions to improve consistency in reporting and thus comparison between Institutions. We support this recommendation.

Implications and risks if recommendation not implemented

Grants may be used ineffectively

The Department's unclear communication of which costs Institutions should recover means that the Department's expectations may not be met. Different cost allocation methods make it hard for both the Department and Institutions to meaningfully compare results between Institutions, to monitor the results of non-credit programs, and to assess if expectations are met. Department grants may support programs not approved by government.

5.2 Monitor Institutions' non-credit programs

Recommendation No. 2

We recommend that the Department of Advanced Education and Technology implement effective processes to:

- **monitor whether Institutions report information consistent with its expectations.**
- **investigate and resolve cases where Institutions' program delivery is inconsistent with its standards and expectations.**

Background

Financial results in central system

The Department's primary monitoring system for Institutions' financial results is its Financial Information Reporting System (FIRS). Institutions report their annual financial results on revenues, direct expenses, and an allocation of overhead costs for credit and non-credit programs in FIRS.

Information compared between Institutions

The Department agrees the information that Institutions enter in FIRS to their annual audited financial statements to ensure that the FIRS information matches, in total, audited amounts. The Department also runs reports from FIRS to compare Institutions by different categories, including non-credit programs. All Institutions can view these reports and compare their own results with those of other Institutions.

Criteria: the standards we used for our audit

The Department should:

- monitor whether Institutions report information consistent with its expectations of which costs to recover for non-credit programs.

- investigate and resolve cases where Institutions' delivery of non-credit programs is inconsistent with an Institution's mandate and other Ministry standards or expectations.

Our audit findings

No follow-up of issues

The Department agrees the information submitted to Institutions' audited financial statements. It contacts Institutions whose direct costs exceed revenues to tell them they may be losing money on their non-credit programs. It is up to the Institution to investigate and decide what to do. Institutions do not have to tell the Department what caused the deficit or what they plan to do about it.

Effective processes may have found problems

With effective monitoring processes, the Department may have identified inconsistencies and errors in the Institutions reporting. Effective processes could include asking Institutions to investigate apparent problems and report to the Minister, reviewing Institutions' investigations, and asking Institutions to resolve problems. In 2004–2005, 9 of 20 public Institutions reported deficits between revenues and direct expenses. Of the 9 Institutions, 6 continued to report deficits on direct expenses for 2005–2006.

Wrong overhead allocations

We identified some of the variances in overhead allocation percentage noted in section 5.1. For example:

- Bow Valley College did not allocate overhead costs for facilities maintenance and operations to the non-credit instruction category.
- Grande Prairie Regional College did not allocate revenue even though it allocated the costs for some non-credit programs, and did not allocate overhead costs for information technology to non-credit programs.
- In 2004–2005, SAIT used its internal allocation methods for the reporting to the Department, while in 2005–2006, it used the Department's recommended allocation model for FIRS reporting. It is unclear from the Institute's methodology why the Institute reported decreases in revenues and direct costs for non-credit programs, while the overhead cost allocation significantly increased from 2004–2005 to 2006–2007.

Implications and risks if recommendation not implemented

Poor decisions from poor data

Grants fund wrong program

The Department may be unable to measure Institutions' performance, and inconsistent data may produce poor decisions. The Department may not identify cases where Institutions are not recovering the relevant program costs, and as a result, Department grants may subsidize non-credit programs, leaving less grants for credit programs.

5.3 Improve policies and expectations for non-credit programs

See Appendix A—Post-secondary Institutions—non-credit programs on page 31 for a listing of the detailed recommendations to the six Institutions we audited.

Criteria: the standards we used for our audit

Institutions should have policies and guidelines to ensure that non-credit programs meet their expectations, and those of the Department. These policies and guidelines should clearly define Institutions' profit or community benefit expectations for non-credit programs, including the costs that Institutions expect different types of programs to recover.

Our audit findings

Establish and communicate expectations for non-credit programs

Expectations of different programs not always clear

Although staff broadly understood their Institution's expectations for non-credit programs, Institutions did not clearly define their profit and community-benefit expectations in policies and guidelines. For example, Institutions may accept recovering only direct costs or part thereof to deliver certain programs such as Aboriginal initiative programs to benefit the community. In other cases, Institutions may want to recover all their costs and still make a profit. The lack of clarity has led to misunderstanding and discrepancies in setting expectations and prices for non-credit programs.

Lack of procedure manuals and training

Program coordinators play an integral role in developing and administering non-credit programs. They regularly deal with the public, and work with contract teachers, program support specialists, and the Registrar's office. They are often responsible for many non-credit programs, especially continuing education programs. Several of the sampled Institutions have significant turnover in this position, but they do not have employee manuals and most staff do not get formal training. NAIT, however, is an example of an Institution that has comprehensive systems that are ISO certified.

Periodically review policies and expectations

No review whether expectations are reasonable

Institutions did not use the cost information they reported to the Department to evaluate if their expectations are reasonable estimates of incremental overhead costs or if they should adjust their expectations. Generally, overhead costs reported to the Department were larger than the costs used by Institutions to set their program prices.

Strengthen code-of-conduct and conflict-of-interest policies

Can strengthen conflict-of-interest policies

While all Institutions have established codes of conduct and conflict-of-interest policies, only NAIT and SAIT require staff to sign annual acknowledgements that they have read, understand and agree to follow the policies. All Institutions should do the same to ensure staff are aware of, and accountable for, following these policies.

Implications and risks if recommendation not implemented

Objectives may not be met

Programs offered by Institutions may not meet expectations of senior management, the Board or the Department. Programs may not achieve intended results, and instead, may systematically lose money. Staff may not act in the best interests of the Institution if they have not agreed in writing to follow the Code of Conduct and conflict-of-interest policy.

5.4 Improve review and approval of non-credit programs

See Appendix A—Post-secondary Institutions—non-credit programs on page 31 for a listing of the detailed recommendations to the six Institutions we audited.

Criteria: the standards we used for our audit

Institutions should review and approve non-credit programs to ensure they are within the Institution's mandate, meet Department standards and expectations, and are consistent with the Institution's objectives.

Our audit findings

Program coordinators often self-assess their own work

Program coordinators are often responsible to initiate non-credit programs, estimate the costs, hire contract trainers, review and arrange course material, and make the final decision to proceed with a course with fewer students than was budgeted for. In effect, they often assess their own work. They may have to cancel a course that they championed. Institutions sometimes rely on management-by-exception where program coordinators and operations specialists are encouraged to notify their supervisors when issues arise. This passive management approach is not always effective; some staff may not have the skills to identify potential issues or may choose not to highlight them for many reasons.

Estimating revenues and costs of proposed non-credit programs

Weaknesses in allocating incremental overhead costs

Institutions do not allocate all incremental overhead costs to non-credit programs. NAIT has a comprehensive program costing worksheet to determine the costs for non-credit programs, including a detailed breakdown of costs for each account in its general ledger that allows it to capture the budget information in its financial system. However, others generally have weaker systems. For example, Grande Prairie Regional College has informal systems to estimate the costs of non-credit programs.

Sensitivity analysis or minimum enrolment targets needed

Institutions make assumptions about enrolment numbers when they estimate the revenues and costs of non-credit programs and tuition fees. While Institutions may have qualitative reasons to continue a course, clearly defining these qualitative reasons, or setting a minimum target when programs are approved, will let program coordinators make better decisions about cancelling or continuing non-credit programs. NAIT establishes minimum and maximum student enrolment numbers and captures this in its student administration system for program coordinators to use, but it can improve the use of its information systems to identify anomalies, such as when student enrolment is below the minimum target.

In adequate justifications or approval for low enrolments

There is no evidence that Institutions' program coordinators, or more importantly, an independent person, assessed or reviewed the reasons to continue a course when actual enrolment was below expected enrolment—potentially not recovering direct costs. For example, several courses had fewer students than expected. In some cases, only one student enrolled, without the course being cancelled.

Evaluating risks and qualitative benefits of proposed programs

Evidence of assessing business and legal risks lacking

Non-credit programs may create various business and legal risks. International non-credit programs may create further risks associated with different business practices or safety of students and staff. But there was little evidence that Institutions evaluated such potential harm.

Improving controls over contracting

Institutions can improve contract systems to varying degrees

Institutions have systems to initiate and approve contracts to offer non-credit programs to public and private organizations, but these systems can improve to varying degrees. NAIT sets standard pay rates for contracted instructors. Some Institutions provided training without contracts, before contracts were signed, or signed contracts without adequate clauses to protect the Institutions.

Implications and risks if recommendation not implemented

May miss goals and incur financial losses

Without accurate estimates of program costs and revenues, and evaluation of program risks, Institutions may not achieve expected results, may incur financial losses due to program failure, and may risk damage to reputation.

5.5 Improve monitoring of non-credit programs and report results

See Appendix A—Post-secondary Institutions—non-credit programs on page 31 for a listing of the detailed recommendations to the six Institutions we audited.

Criteria: the standards we used for our audit

Institutions should monitor non-credit programs they offer and report the results to senior management and boards.

Our audit findings

Program monitoring and reporting

Institutions monitor revenue and direct costs

The level of detail reported to management varies between Institutions. NAIT compares actual revenues and expenses to budgets, and prepares quarterly reports to its management, with variance explanations. Grande Prairie needs to improve its reporting to management and the board significantly, as described on page 183.

Institutions don't allocate overhead costs in accounting systems

Only NAIT and SAIT allocate incremental overhead costs to non-credit programs in their accounting systems. Other Institutions do not report all incremental overhead costs to program coordinators, management or the board to give them complete and accurate information to make decisions that are informed. The financial information that Institutions reported to the Department provides some context for overhead costs for Institutions. Reports to senior management and Boards show profits for non-credit programs because they often consider only direct costs. But when overhead costs reported to the Department are considered, all Institutions reported a deficit for non-credit programs. Although some of this overhead cost that Institutions allocate to non-credit programs may be considered sunk costs, it provides information that should be considered.

Contract monitoring

Improve monitoring of third-party services

Although Grande Prairie Regional College monitor the financial aspects of their programs delivered by third parties, there is no evidence that they effectively monitor the quality of service provided or other non-financial aspects.

Program evaluations and performance measurements

Improve measuring student satisfaction results against benchmarks

Only Red Deer College and NAIT set benchmarks and compared the results from student course evaluation surveys against the benchmark. Other Institutions conduct student evaluations for all or only some of their non-credit programs, but the data from these evaluations is not consistently compiled, analysed or reported to senior management. Generally, program coordinators only read surveys, focusing on comments and then discarded them.

Implications and risks if recommendation not implemented

Low-quality programs, unmitigated risks may occur

Lack of effective monitoring of non-credit programs may result in poor decision-making and programming quality. It also exposes the Institution to unmitigated risks and liabilities.

Appendix A—Post-secondary institutions—non-credit programs recommendations

Appendix A—Post-Secondary Institutions—non-credit programs recommendations

College	Title	Recommendations made to management
Bow Valley College	Set non-credit program policies and expectations	We recommend that Bow Valley College: • document its policies for non-credit programs and communicate them to staff. • report relevant direct and overhead cost information for non-credit programs to program coordinators, senior management and the Board.
	Estimate costs and approve non-credit programs before they start	We recommend that Bow Valley College improve its processes to review and approve whether to offer or continue to offer each non-credit program. This includes: • improving its processes to estimate revenues and costs to offer non-credit programs and establishing minimum enrolment targets to use when deciding whether to continue with non-credit programs. • documenting its assessment of the business and legal risks associated with non-credit programs. • monitoring and reporting enrolments for continuing education programs.
	Evaluate non-credit programs	We recommend that Bow Valley College improve its processes to evaluate non-credit programs by: • setting clear expectations to assist in measuring their success. • compiling and analyzing student evaluations. • reporting the results to management. • solving issues noted in student evaluations.
	Require staff to annually acknowledge ethical business practices policy	We recommend that Bow Valley College implement an annual sign-off for its Ethical Business Practices Policy for employees.
Grande Prairie Regional College	Improve non-credit program policies and expectations	We recommend that Grande Prairie Regional College: • review its policies for non-credit programs to ensure they are current. • report relevant direct and overhead cost information for non-credit programs to program coordinators, senior management and the Board. • improve its processes to prepare accurate, complete and relevant financial data that it reports to the Department of Advanced Education and Technology.
	Provide staff training on budgeting and monitoring non-credit programs	We recommend that Grande Prairie Regional College provide formal training to all individuals involved in budgeting and monitoring non-credit programs.

College	Title	Recommendation
Grande Prairie Regional College con't	Estimate costs and approve non-credit programs before they start	We recommend that Grande Prairie Regional College implement adequate processes to review and approve program proposals and estimates before programs start. This includes: • estimating revenues and costs to offer non-credit programs and establishing minimum enrolment targets to use when deciding whether to continue with non-credit programs. • documenting assessments of the business and legal risks of non-credit programs. • monitoring and reporting enrolments for non-credit programs.
	Evaluate non-credit programs	We recommend that Grande Prairie Regional College improve its processes to evaluate non-credit programs by: • setting clear expectations to assist in measuring their success. • compiling and analyzing student evaluations. • reporting the results to management. • solving issues noted in student evaluations.
	Improve contract-management systems	We recommend that Grande Prairie Regional College improve its contract-management systems by: • signing contracts before providing services. • including sufficient terms and conditions in instructors' contracts for non-credit programs. • complying with the *Income Tax Act*. • implementing adequate monitoring processes for contracted services. • maintaining a complete inventory of contracts.
	Specify roles and responsibilities for IT management	We recommend that Grande Prairie Regional College: • clearly define roles and responsibilities for strategic planning and oversight of information technology. • implement efficient processes to minimize manual entries of student tuition fees.
	Require staff to annually acknowledge Code of Ethics policy	We recommend that Grande Prairie Regional College implement an annual sign-off for its Code of Ethics Policy for employees.
Northern Alberta Institute of Technology	Estimate costs and approve non-credit programs before they start	We recommend that the Northern Alberta Institute of Technology enhance its processes to review and approve non-credit programs. This includes: • improving the use of its information systems to identify courses with actual enrolments that are below minimum enrolment targets. • documenting its approval for courses to continue where enrolments are below the minimum enrolment targets. • signing contracts before services start.

College	Title	Recommendation
Olds College	Set non-credit program policies and expectations	We recommend that Olds College: • document its policies for non-credit programs and communicate them to staff. • review its budget process to reflect overhead costs that are consistent with actual overhead cost experience. • report relevant direct and overhead cost information to program coordinators, senior management and the Board.
	Provide staff training	We recommend that Olds College provide formal training to all individuals involved in budgeting and monitoring non-credit programs.
	Estimate costs and approve non-credit programs before they start	We recommend that Olds College improve its processes to review and approve whether to offer or continue each non-credit program. This includes: • improving its processes to estimate revenues and costs to offer non-credit programs and establishing minimum enrolment targets to use when deciding whether to continue with non-credit programs. • documenting approved budgets and expectations, and key decisions made. • approving programs before services or training start. • documenting its assessment of the business and legal risks associated with non-credit programs.
	Evaluate non-credit programs	We recommend that Olds College improve its processes to evaluate non-credit programs by: • setting clear expectations to assist in measuring their success. • compiling and analyzing student evaluations. • reporting the results to management. • solving issues noted in student evaluations.
	Improve contract management systems	We recommend that Olds College improve its contract management processes by: • signing contracts for all services before services start. • including sufficient terms and conditions in contracts.
	Require staff to annually acknowledge ethical business practices policy	We recommend that Olds College implement an annual sign-off process for its Code of Conduct and Conflict of Interest Policies for employees.
Red Deer College	Improve non-credit program policies and expectations	We recommend that Red Deer College: • document its policies for non-credit programs and communicate them to staff. • review its budget process to reflect overhead costs that are consistent with actual overhead cost experience. • report relevant direct and overhead cost information for non-credit programs to program coordinators, senior management and the Board.

College	**Title**	**Recommendation**
Red Deer College con't	Estimate costs and approve non-credit programs before they start	We recommend that Red Deer College improve its processes to review and approve whether to offer or continue to offer each non-credit program. This includes: • improving its processes to estimate revenues and costs to offer non-credit programs and establishing minimum enrolment targets to use when deciding whether to continue with non-credit programs. • documenting its assessment of the business and legal risks associated with non-credit programs. • monitoring and reporting enrolments for continuing education programs.
	Clarify policy to ensure proper approval of contracts	We recommend that Red Deer College: • clarify its policy to indicate those individuals who are authorized to sign non-credit contracts. • sign contracts for all services before services start.
	Implement regular sign off of its Conflict of Interest Policy	We recommend that Red Deer College implement an annual sign-off process of its Conflict of Interest Policy for employees.
Southern Alberta Institute of Technology	Set non-credit program policies and expectations	We recommend that the Southern Alberta Institute of Technology: • document its policies for non-credit programs and communicate them to staff. • improve its processes to prepare accurate reliable data that it reports to the Department of Advanced Education and Technology. • improve reports of direct and overhead cost information to senior management and the Board. • review its overhead cost allocation in the Institute's budget and reports to the Department.
	Estimate costs and approve non-credit programs before they start	We recommend that the Southern Alberta Institute of Technology implement adequate processes to review and approve program proposals and estimates before programs start. This includes: • improving its processes to estimate revenues and costs to offer non-credit programs and establishing minimum enrolment targets to use when deciding whether to continue with non-credit programs. • documenting its assessment of the business and legal risks associated with non-credit programs. • monitoring and reporting enrolments for continuing education programs.
	Provide staff training	We recommend that the Southern Alberta Institute of Technology enhance formal training to all individuals involved in budgeting and monitoring non-credit programs.
	Monitor programs administered by contracted program coordinator	We recommend that the Southern Alberta Institute of Technology independently monitor non-credit programs administered by a contractor.

College	Title	Recommendation
Southern Alberta Institute of Technology con't	Evaluate cost-recovery programs	We recommend that the Southern Alberta Institute of Technology improve its processes to evaluate non-credit programs by: • setting clear expectations to assist in measuring their success. • compiling and analyzing student evaluations. • reporting the results to management. • solving issues noted in student evaluations.

Monitoring vocational programs and degrees offered by private institutions

1. Summary

Public and private institutions deliver advanced education in Alberta

A range of public and private institutions, as well as business enterprises, deliver advanced education in Alberta. Private vocational programs delivered by private institutions are regulated under the *Private Vocational Training Act*. Private university-colleges are regulated under the *Post-secondary Learning Act*.

We focused on private institutions

We examined if the Department of Advanced Education and Technology has effective systems to:

- license private vocational programs and monitor private institutions' compliance with legislation. We also examined if the Department has effective processes to deal with student complaints and alleged non-compliance matters raised about CDI College. Questions were raised at the Public Accounts Committee meeting of November 14, 2007[1], and there also were issues raised in the media about CDI College.
- approve degree programs offered by private university-colleges and to monitor their use of grants and results achieved.

Effective systems to license and monitor programs exist, but audit process can improve

The Department has effective systems to license private vocational programs and monitor private institutions' delivery of these programs, but the Department can improve its new compliance audit process. It has adequate processes to investigate student complaints, and it followed these processes when it investigated the complaints about CDI College. It also has effective systems to approve degree programs offered by private university-colleges, monitor their use of grants and results achieved.

Department should:

- develop strategic audit plan

We recommend that the Department:

- develop a strategic audit plan of new and follow-up audits of private institutions, including timelines and resources requirements. Without it, the Department may not be able to measure if it is achieving its objectives for monitoring private institutions, or to monitor the progress of a professional service firm it hired to audit private institutions' compliance with legislation.

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[1] www.assembly.ab.ca/net/index.aspx?p=pa&section=doc&fid=29

- issue non-compliance information promptly

- report orders and information on non-compliance issues to Institutions within a reasonable time after completing the audit. Compliance audits take approximately four days to complete, but it takes approximately three months, and in one case seven months, to report explanations of non-compliance issues to private institutions. The Department may not identify and deal with non-compliance issues promptly.

2. Audit objectives and scope

2.1 Our audit objective

We assessed if the Department has effective systems to:

- fulfill its legislative responsibility under the *Private Vocational Training Act* and the *Post-Secondary Learning Act* for:
    - granting licenses for private vocational programs delivered by private institutions;
    - ensuring private vocational schools comply with the requirements of the Act and license conditions;
    - approving and monitoring of degree programs offered by private university-colleges.
- ensure that private university-colleges are appropriately accountable for the use of provincial grants.

2.2 Our scope

We examined the Department's processes to:

- license vocational programs offered by private institutions.
- monitor their compliance with legislation.
- approve degree programs for private university-colleges.
- monitor private university-colleges' use of grant funds.

3. Background

Licensed Vocational Programs

Private Vocational Training Act regulates vocational programs

Approximately 150 private vocational schools deliver private vocational programs that teach students essential skills for a vocation or career, such as paramedic or hairstylist. These programs are regulated under the *Private Vocational Training Act*. This Act and its regulations set criteria for obtaining and retaining licenses, such as bonding requirements, use of, and compliance with, standard student contracts, relevancy of the program, and instructor qualifications.

Campus Alberta Quality Council reviews degree programs' proposals for quality

Private university-colleges

Eight private colleges can offer degree programs in Alberta. The Lieutenant Governor in Council must approve new degree programs private university-colleges plan to offer. The Department first reviews proposals for new degree programs to evaluate the need for the program in Alberta's post-secondary system. Then, the Campus Alberta Quality Council[2] (the Council) reviews successful proposals to ensure they meet quality standards, and recommends that the Minister approve or reject the proposal. The Council also periodically evaluates approved degree programs to ensure that private institutions continue to meet quality standards. Seven of the eight private university-colleges are Alberta non-profit organizations that receive some operating grant support for their degree programs from the Department.

4. Conclusions

Effective systems exist, but audit process can improve

The Department has effective systems to license private vocational programs and monitor private institutions' delivery of these programs, but the Department can improve its new compliance-audit process. It also has effective systems to approve degree programs offered by private university-colleges, and monitor their use of grants and results achieved.

Department investigated complaints at CDI College

Director ordered them to fix non-compliance issues

The Department has adequate processes to investigate student complaints, and it followed these processes when it investigated the complaints about CDI College. As part of their monitoring, private institutions must have processes to deal with student complaints.[3] If a complaint is not resolved, students can ask the Department to investigate it. The Director of Private Vocational Training at the Department ordered CDI to address concerns raised in a television report that a CDI College staff member guaranteed students they would get jobs—a contravention of the *Private Vocational Training Act*. The Director then followed up to ensure compliance. Some of the complaints did not involve compliance issues. For example, one student said CDI refused to provide a certificate for the program, but the student had not fully paid the tuition fee. Private institutions may withhold certificates and transcripts from students who owe fees.

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[2] An advisory agency established under the *Post-secondary Learning Act*

[3] *Private Vocational Schools Regulation 5(1)(g)*

Table 1—Department's results in meeting criteria

	Criteria	Conclusion			
		Met	Partly met	Not met	Related numbered recommendation
4.1	Licensing vocational programs offered by private institutions according to legislation.	√			
4.2	Monitoring private institutions' compliance with legislation for licensed programs, and reporting results to the Minister.		√		5.1
4.3	Approving university-colleges' degree programs according to Department standards.	√			
4.4	Monitoring university-colleges' use of grant funds and results achieved.	√			

4.1 Licensing vocational programs offered by private institutions according to legislation

Effective processes to license vocational programs

The Department met the criteria. It has established licensing standards to support the legislative requirements for private vocational programs. It has effective processes to ensure that vocational programs offered by private institutions meet the licensing requirements before it grants licenses. The Department evaluates the relevance of licensing requirements used to approve and monitor programs, and proposes changes to legislation as needed.

4.2 Monitoring private institutions' compliance with legislation for licensed programs, and reporting results to the Minister

Effective processes to monitor compliance and investigate complaints

The Department partly met the criteria. It investigates and deals with potential non-compliance with legislation. Records of past non-compliance are available to staff who process license applications or investigate compliance issues. The Department has evaluated the risk of non-compliance with legislation and has adequate processes to detect private institutions offering programs without a license.

Effective processes, but Department must:
- develop strategic audit plan
- issue compliance information promptly

The Department also has processes to monitor Institutions' compliance with licensed program requirements. It has contracted with a private-sector professional services firm for 2 years to audit Institutions' compliance with legislation, and student loan requirements. The Department has detailed audit programs and guidelines for the audits. It meets with private institutions to discuss any non-compliance problems and, if any significant deficiencies were noted, the Director orders the Institution to correct them. The Department provides information to the Minister on the results of its monitoring activities. But it has not documented a strategic plan, including time lines and resources to audit the private institutions. Additionally, the Department is not issuing reports promptly. See recommendation 5.1.

4.3 Approving university-colleges' degree programs according to Department standards

Effective processes to approve university-colleges' degree programs

The Department met the criteria. The Department, with the Campus Alberta Quality Council (the Council), has established relevant standards to evaluate proposed degree programs and the organizational standards of private institutions. These standards are being harmonized with other provinces through Canada's *Ministerial Statement on Quality Assurance of Degree Education in Canada*[4] issued by the Canadian Council of Ministers of Education, Canada. The Department and Council established annual and periodic reporting requirements for private institutions offering degree programs to evaluate their continued compliance with Council and Department standards. The Council investigates issues previously identified from private institutions' annual reporting and follows up to ensure they resolve issues.

Campus Alberta Quality Council does comprehensive reviews every 5 years

The Council also does a comprehensive review five years after approving a degree program. Institutions first carry out a self-study of the approved degree program. The Council then contracts with an external team to evaluate the self-study and do its own comprehensive review. The Council has established standards and guidelines for the self-studies and comprehensive reviews. The Council also solicits feedback from evaluation teams and private institutions on its standards, guidelines and processes, to identify opportunities for improvement.

4.4 Monitoring university-colleges' use of grant funds and results achieved

Department reviews use of grant funds and results achieved

The Department met the criteria. The Department has defined the entities and programs that may be funded, and provides funds in accordance with the funding policy approved by the Minister. The Department requires private university-colleges to provide the same accountability reporting as public institutions, including financial and enrolment data, business plans, and audited financial statements. The Department reviews the enrolment, budgets and financial results for private university-colleges, and acts, with institutions, to resolve issues or anomalies.

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[4] http://www.cmec.ca/releases/press.en.stm?id=51

5. Recommendation

5.1 Monitoring vocational programs offered by private institutions

Recommendation

We recommend that the Department of Advanced Education and Technology:

- **develop a risk-based strategic audit plan of new and follow-up audits, including timelines and resources to audit private institutions.**
- **issue Orders and information on deficiencies within a reasonable time after completing the audit.**

Background

Compliance audit process recently implemented

The Department is responsible to monitor private institutions' compliance with legislation. In May 2007, the Department contracted with a professional services firm to audit all private institutions' compliance with legislation. The Department plans to audit approximately 150 private institutions located all across Alberta. The Department reviews the firm's reports that detail any non-compliance issues, reports results to the institution, and requests a response on actions the institution will take to resolve the issue. The Department may order private institutions to correct significant non-compliance with legislation. The Director of Vocational Training may suspend or cancel licenses for vocational programs if institutions do not comply with legislation.

Criteria: the standards we use for our audit

The Department should monitor vocational programs that private institutions offer to ensure they comply with applicable legislation and program licensing requirements as set out in legislation.

Our audit findings

Department has systems to monitor, but audit process can improve

The Department has systems to monitor private institutions' compliance with legislation. Although this is the first year of the Department's compliance-audit process, it can improve its systems in the following areas.

No strategic plan to audit private institutions

For the first year, the Department selected 26 institutions to audit based on a risk assessment of the number of student complaints and student loan repayment rates for their programs. The Department completed 15 audits to February 19, 2008. The Senior Licensing Consultant maintains a record of the audits to be performed during the year that indicates the proposed timing and progress of each individual audit. However, the Department has not developed a risk-focused strategic plan of the private institutions it plans to audit in future years, with timelines and resources, allowing enough time and resources to follow-up institutions with significant compliance issues. This overall plan will help the Department monitor its progress towards its goal of auditing private institutions, and set clear expectations for the professional services firm.

Information on non-compliance issues not reported promptly

Although the Department implemented the audit process during the year, it is not issuing its Compliance Review Reports to institutions promptly. An average on-site compliance audit takes about 4 days, but it takes about 3 months or more for the Department to issue the reports. For example, Academy of Learning was initially audited in July 2007—with no report issued as of February 2008. The Department indicated that it sometimes requires the professional services firm to conduct further tests based on the issues found, which delays completion of the audit. However, this would not explain a 7-month delay. The reports the Department receives from the professional services firm differ from the final reports the Department issues to private institutions. The Department may consider requesting the firm to draft their report in the same format as the final report to avoid any rework and improve timeliness of reporting.

Implication and risks if recommendation not implemented

The Department may not achieve its objective of auditing private institutions, resulting in non-compliance issues going undetected or unresolved.

Northern Alberta Institute of Technology—construction-management processes

1. Summary

NAIT plans $94 million for new infrastructure

The Northern Alberta Institute of Technology has found that the Alberta economy is driving the demand for more skilled workers. In 2004, the Institute embarked on a number of capital projects totalling approximately $94 million to respond to the increased demand for skills training. In support of this, the Institute launched a $50-million fundraising campaign in 2005. The Institute received capital grants of approximately $38 million (41%) from the Government of Alberta and the remaining $56 million (59%) from other funding sources, mainly through the fundraising campaign. The planned capital projects over the ensuing 10 years encompass a number of new and renovated centers of excellence.

Our audit objective

The objective of our audit was to assess whether the Institute has effective construction-management systems for the planning, budgeting, tendering, awarding, monitoring and reporting of construction projects.

Good systems exist, but they can improve

We conclude that the Institute has comprehensive and well-designed construction-management systems. These systems operate as intended, but the Institute can further strengthen them.

One recommendation

We made one recommendation to the Institute to include conflict-of-interest provisions in construction-management contracts, and document the reasons and approval for sole-sourcing contracts.

No record to explain sole-sourced contract or conflict of interest

The Institute's outsourced construction manager entered into a sole-sourced contract for $666,000 with a company that pledged $1 million ($600,000 received to date) for naming rights on a building. The President of this company is also a Board Member of the Institute and the Chair of the Institute's Campus Development Committee. Management told us they believe the construction manager was acting in the best interests of the Institute when they entered into the contract. Currently, the Institute's sole-sourcing guideline, requiring 3 written proposals for contracts greater than $10,000, does not apply to sub-contractors of the outsourced construction manager. However, given the Institute's approval of this sole-sourcing decision, and the appearance of a conflict of interest for the Board Member, we believe that the Institute should have documented its justification and approval of the decision to protect its reputation and that of the parties it does business with.

2. Audit objective and scope

2.1 Our audit objective

Are systems to manage construction effective

The audit objective was to assess if the Institute has effective construction-management systems for the planning, budgeting, tendering, awarding, monitoring and reporting of construction projects. To make this assessment, we developed audit criteria that management agreed with.

2.2 Our scope

We examined the Institute's:

- policies and procedures for construction management.
- systems to plan, budget for, award tenders for, monitor, and report progress of construction projects.

We did not examine the Institute's systems to plan and optimize the use of its existing facilities.

3. Conclusions

Good systems, but they can improve

The Institute has comprehensive and well-designed construction-management systems. These systems operate as intended, but the Institute can further strengthen them. The Institute fully met five criteria and partly met one.

Table 1—Institute's results in meeting criteria

	Criteria	Conclusion			
		Met	Partly met	Not met	Related recommendation
3.1	Clearly define needs and requirements for construction.	√			
3.2	Clearly define roles and responsibilities.	√			
3.3	Define project scope, including required activities, time and resources.	√			
3.4	Procurement, selection of service providers, and approval of contracts.		√		4.1
3.5	Monitor contractor performance.	√			
3.6	Finalize and evaluate projects.	√			

3.1 Clearly define needs and requirements for construction

Needs and requirements clearly defined and reviewed

The Institute met the criteria. It uses the Ministry of Infrastructure and Transportation's business case template to assess the needs for capital projects. The business case includes key components such as risk assessments, cost-benefit analysis, project cost-estimates, funding and spending plans, an assessment of the Institute's existing capacity and facility utilization rate, and information on how the project aligns with the Institute's long-term capital planning priorities. The Executive, Campus Development Committee and the Board discuss and challenge business cases.

3.2 Clearly define roles and responsibilities

Roles and responsibilities clearly defined and understood

The Institute met the criteria. Its Campus Development Guideline clearly defines the governance model and the roles and responsibilities of various committees. The Board of Governors' Campus Development Committee is responsible to review, approve and monitor construction activities. The Director of Capital Projects is ultimately responsible for project management and coordination. Various consultants and the construction manager support him. Their roles and responsibilities are set out in standard contracts established for the construction industry in Canada. The Institute clearly defines the Capital Projects Department's staff responsibilities and functions and staff understand their roles.

3.3 Define project scope, including required activities, time and resources

Scope, activities, and resources clearly defined

The Institute met the criteria. It clearly defines project scope, including cost estimates and resources required, and details the specific construction activities to be performed using Gantt charts that include timelines and milestone dates. The project schedules provide adequate information to allow the construction-management team to manage the project timelines and identify when critical resources will be required.

3.4 Procuring and selecting service providers, and approving contracts

Policies good, but contracts lack adequate conflict-of-interest clauses and sole-sourcing guidelines need improvement

The Institute partly met the criteria. It has policies and procedures for tendering and selecting service providers for construction contracts. However, the Institute's sole-sourcing guideline does not extend to sub-contractors without fixed price contracts, and construction-management contracts do not have adequate conflict-of-interest clauses to allow the Institute to identify, report and deal with potential conflicts of interest. And the Institute did not properly document the reasons for its approval of one sole-sourced contract—see recommendation 4.1.

3.5 Monitor contractor performance

Regular reviews of contractor performance and reports to management and committee

The Institute met the criteria. It controls the progress of construction projects through bi-weekly meetings of its capital projects team, the architect, the construction manager, and the sub-consultants. The architect performed bi-weekly site inspections to assess the status and progress of work. The Director of Capital Projects reports the project status and activities to senior management and the Campus Development Committee, and provides monthly reports to the Ministry of Infrastructure and Transportation.

3.6 Finalize and evaluate projects

Final payments released only after problems fixed

The Institute met the criteria. It receives Certificates of Substantial Performance of Prime Contract that include estimates for the cost of work remaining to remedy deficiencies after the building handover dates. Senior management approves the final release of holdback payments after it verifies that the construction manager corrected any noted deficiencies. The Institute's capital projects staff meet informally with the architect and construction manager at the end of each major project. In addition, program heads are encouraged to attend site inspections throughout the construction period and to identify any issues during the construction-warranty period.

4. Findings and recommendations

4.1 Selection processes

Recommendation

We recommend that the Northern Alberta Institute of Technology:

- **include conflict-of-interest provisions in construction-management contracts.**
- **improve its sole-sourcing guidelines to require, where appropriate, adequate documentation of justification and approval for construction-contract work that is sole-sourced.**

Background

Conflict-of-Interest Code and Guideline exist

The Institute has a *Conflict-of-Interest Code* and *Conflict-of-Interest Guideline*. The Code provides guidance to all Institute employees. The Guideline provides some examples of a conflict of interest and indicates that full disclosure is one of its key principles. If a conflict of interest occurs, the Institute will impose sanctions up to and including dismissal. In addition, the Institute's Board of Governors By-Laws specify the conflict-of-interest matters on which Board members must abstain from voting.

Outsourced construction manager to arrange sub-contractor tender process

The Institute requires its outsourced construction manager to arrange the tender process for sub-contractors. The Campus Development Committee reviews the tender amounts for various trades, but not the names of the sub-contractors, or whether work was publicly tendered. Using these tender results and the budget, the Institute enters into a fixed-price contract with the construction manager. The Committee then authorizes the construction manager to enter into a contract with each sub-contractor using a standard construction-contract agreement.

Institute has sole-sourcing guideline

The Institute's sole-sourcing guideline states that contracts for more than $10,000 require a minimum of three written proposals to help ensure the Institute pays a competitive price. The guideline does not apply to subcontractors without fixed price contracts.

Criteria: the standards we used for our audit

The Institute should have effective systems over procurement, selection of service providers, and approval of contracts. This includes effective systems to deal with conflict of interest.

Our audit findings

The Institute partly met the criteria, as section 3.4 on page 47 explains.

Conflict-of-interest policy

Staff sign they will abide by conflict-of-interest policies

The Institute maintains and enforces a conflict-of-interest policy. When employees start work and annually, they confirm in writing that they accept and will comply with the policy. The Institute clearly defined and communicated the expectations for disclosure and avoidance of potential conflicts of interest and the types of commitments that will interfere with employees' duties.

Although the Institute has clear policies and procedures on conflict of interest and guidelines on sole-sourcing of contracts, it has the following weaknesses in its policies, procedures and guidelines:

No conflict-of-interest clauses in contracts

- There are no conflict-of-interest provisions in the Institute's construction-management contracts. Contracts do not include any requirement for outsourced contractors to confirm that they, or the parties with whom they contract, do not have a conflict of interest related to the Institute's construction project. In addition, the Institute does not have effective processes to identify, assess and properly manage the risk of potential conflict of interest as appropriate and report it to the Board.
- The sole-sourcing guideline does not address cases where the Institute's contractors sole source work to sub-contractors.

Board member followed process when naming facility

A company[1], whose President and CEO is a Board Member and the Chair of the Campus Development Committee, pledged $1 million towards the construction of a facility. The amount is payable in annual instalments of $200,000 over 5 years and was publicly announced on February 15, 2005. To recognize the pledge, the company received naming rights for the new facility. The Campus Development Committee meeting minutes for November 23, 2004 confirm that the Chair properly abstained (in accordance with the Board of Governors By-Laws) from voting on the decision to name the facility. The minutes also properly disclosed the pledge. The Institute signed a Donation and Recognition Agreement in June 2005 with the company.

Structural steel work sole-sourced to company of which Board member is President

The Institute followed its policies and procedures when selecting the outsourced construction manager. On April 5, 2005, the outsourced construction manager for this project started the tendering process with sub-contractors. The construction manager did not publicly tender the structural steel—it was to be sole-sourced to the company of which the Board Member is the President and CEO. Miscellaneous steel required for the project was awarded to a different contractor.

However, on April 28, 2005, the Campus Development Committee reviewed the tender results for the sub-contractors. On May 3, 2005, the Institute signed a fixed-price contract with the construction manager, based on the tender results for the sub-contractors, and the budget for the project. On May 5, 2005, the construction manager signed a sub-contracting agreement with the company for the structural steel work for $666,000. The following problems occurred:

Justification and approval not documented

- Management did not identify or document the justification or approval for planning to sole-source this work. Management did not obtain other written proposals for the sole-sourced steel contract to assess if $666,000 was reasonable.

Potential conflict of interest not identified

- The Campus Development Committee meeting minutes do not indicate that the Committee considered the potential conflict-of-interest implications of awarding this sole-sourced contract. The minutes also do not indicate that the Chair of the Committee disclosed his company was a sub-contractor, or that the Chair abstained from the meeting to review the tender results on April 28, 2005.

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[1] Waiward Steel Fabricators Ltd.

Management explained verbally

Management told us that sole-sourcing was necessary because there was a tight timeline to have the steel work substantially complete before winter 2005 to save on heating costs, and to complete the project to meet the anticipated teaching schedules for the summer of 2006. Management also said it was difficult to find steel contractors due to the tight market conditions in early 2005. Further, management believes the decision was in the best interest of the Institute, and was consistent with the concept of developing innovative partnerships, which it believes necessary to carry out its current capital plans.

However, given the sole-sourcing of a large contract and the potential conflict of interest, we believe the Institute should have properly documented and approved the sole-sourcing decision. Also, the Chair of the Committee should have disclosed the fact that his company was a sub-contractor, and abstained from the meeting to review the tender results that formed the basis for the fixed-price contract with the construction manager.

Implications and risks if recommendation not implemented

Reputation of Institute and donors at risk without documented support

Without appropriate documentary evidence supporting the decision to award a contract to a service provider, the Institute may not be able to show that it followed a tendering process that was open and transparent and achieved value for money. Without processes to identify potential conflicts of interest, the Institute may inadvertently have a conflict of interest and damage its reputation, as well as the reputation of parties doing business with the Institute.

Department of Energy's system for identifying and managing conflicts of interest

1. Summary

Request to examine Executive Director's potential conflict of interest

In July 2007, we received a request to examine a potential conflict of interest involving the (then) Department of Energy's Executive Director—Electricity Division.[1] A year earlier, on June 15, 2006, the Executive Director had sent a letter to the Alberta Energy and Utilities Board (EUB) urging it to proceed expeditiously with a Review and Variance hearing for a proposed 500 kV line to be built between Edmonton and Calgary. The alleged conflict of interest arose because the Executive Director's then spouse was a senior manager at the company that would build and operate the power line if the approval was granted through EUB's regulatory hearing process.

Examined Department systems to identify and manage conflicts of interest

We assessed whether the Department's system for identifying and managing conflicts of interest was followed in the Executive Director's case. We interviewed department staff and reviewed the relevant policies to learn how the system is designed to work. We also reviewed pertinent documentation, such as the Executive Director's declarations on conflicts of interest, the June 15 letter he sent to the EUB, and other Department submissions to the EUB during the hearing. Also, we considered whether any Department submissions to the EUB suggested the Executive Director was using his influence to benefit himself or his then spouse.

Executive Director met requirements

We concluded that the Department has a system in place to identify and manage conflicts of interest. The Executive Director disclosed his situation to senior management and met the requirements of the *Code of Conduct and Ethics for the Public Service of Alberta*. We saw no evidence in the Department's submissions to the EUB that the Executive Director used his position to influence the EUB's hearing process to benefit himself or his then spouse. We also concluded that the Executive Director did not have an actual conflict of interest by participating in the EUB's hearing processes for the 500 kV line. However, we made one recommendation to the Department to ensure that when an employee declares a potential conflict of interest, the resulting discussions, conclusions, and mitigating actions are clearly documented according to the Department's defined process.

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[1] Kellan Fluckiger

2. Audit objectives and scope

Our objectives were to assess:

- if the Department of Energy has a system to identify and manage conflicts of interest, and
- if that system was followed in the Executive Director's case.

Did Department comply with its own policies

We reviewed the Department of Energy's policies and procedures on conflicts of interest and the documented declarations the Executive Director made on conflicts of interest when he was under contract with the Department, from July 2003 to October 2007.

Focus on Department's system to identify and manage conflicts of interest

We did not audit the EUB's process for assessing applications and evidence submitted to it. Nor did we audit the Alberta Electric System Operator's (AESO) process for preparing the needs application for the 500 kV line that was the subject of the hearing. Further, we did not assess the Department's decision to send the June 15, 2006 letter to the EUB—beyond examining whether the decision was influenced by the Executive Director's potential conflict of interest.

3. Energy's system to identify and manage conflicts of interest

The Code of Conduct and related documents

Three documents form the foundation of the Department's policies and processes for identifying and managing conflicts of interest:

- *Code of Conduct and Ethics for the Public Service of Alberta*
- *Code of Conduct Administrative Guidelines*
- *Code of Conduct and Ethics—Supplementary Code and Administrative Procedures*

The *Code of Conduct and Ethics for the Public Service of Alberta* describes the primary requirements for all Alberta public service employees concerning conflicts of interest, while the *Code of Conduct Administrative Guidelines* provides guidance on how to apply the Code. The *Code of Conduct and Ethics—Supplementary Code and Administrative Procedures* details the Department of Energy's specific processes for identifying and managing conflicts of interest.

Both codes apply to contract employees

Alberta Corporate Human Resources administers the cross-government *Code of Conduct and Ethics for the Public Service of Alberta* (the *Public Service Code*) along with the *Administrative Guidelines* (the Public Service Guidelines). The Public Service Code permits Departments to have their own supplementary code—as long as it's not more permissive than the Primary Public Service Code. The Department of Energy's *Code of Conduct and Ethics—Supplementary Code and Administrative Procedures* (the Department's Supplementary Code) was in effect during the Executive Director's contract with the Department. Both the *Public Service Code* and Department's Supplementary Code apply to public service employees and employees hired on a contract.

Section 8 of the Public Service Code indicates that employees violate the code if they "use their public roles to influence or seek to influence a government decision which could further a private interest of theirs or of their spouse or minor child." The Public Service Code also indicates employees are expected to "withdraw from any decisions where they know that the decision could affect a private interest of theirs or of their spouse or minor child."

The Public Service Guidelines indicate a "conflict of interest" exists when:

- "employees have a private or personal interest sufficient to influence or to appear to influence the objective exercise of their official duties;
- the private interests of employees are "at variance" or "in conflict" with their official duties and responsibilities to government; and
- employees gain or appear to gain an advantage (for self or others) by virtue of their public service role."

An apparent conflict of interest is defined in the Public Service Guidelines as "a conflict which can be deduced from appearances or where there is a reasonable apprehension or likelihood that a conflict exists."

Broad consideration of apparent conflicts to identify potential conflicts of interest

One difficulty in assessing apparent conflicts of interest is that they depend on how much information a "reasonable" observer is assumed to know about an individual's circumstances. The Public Service Code highly encourages employees to disclose any potential conflicts of interest so that management can make informed assessments to protect the public interest and reputation of the Department and employee. For that purpose, using the broadest consideration of apparent conflicts results in the most disclosure and management assessment.

But using such a broad consideration to decide if an employee can maintain their employment or carry out their duties may be unnecessarily restrictive to protect the public interest. This is why, once an employee has disclosed any potential conflicts of interest, the Public Service Code gives each deputy minister the responsibility to determine what restrictions, if any, are necessary to protect the public interest on a case-by-case basis. In making this determination, the deputy minister can consider facts beyond what a "reasonable" observer may know.

The Public Service Guidelines also provide the following two principles to assess conflict situations:

- "The first principle is openness. Employees are required to discuss with department management any actions or situations where conflicts may occur. When private interests are freely and frankly declared, the possibility of conflict is greatly lessened.
- The second principle is that public employees should enjoy the same rights in their private dealings as any other citizens unless it can be demonstrated that a restriction is essential to the public interest."

Code does not require disclosure to be documented

Section 7 of the Public Service Code requires employees to disclose any situation involving them that is a conflict or an apparent conflict of interest. However, neither the Public Service Code nor Public Service Guidelines specify the format of this disclosure or explicitly require it to be documented.

The Department's process

The Department's Supplementary Code states that:

> "In any situation where:
>
> - an employee's impartiality could be questioned, or
> - a situation arises which is or may become a conflict of interest or an apparent conflict of interest
>
> the employee will provide disclosure of information."

Department uses 2 forms

The Department's process includes using two forms to help employees make the declaration. The first one, called the "Non-conflict certification" is essentially a "yes" or "no" questionnaire. Employees who indicate "no" situations meet the above criteria, don't complete the second form. Employees who indicate that a situation may appear to result in a conflict of interest, complete a second form, called the "Disclosure" form, with details of the situation.

When a Disclosure form is completed, the employee sends it to the Executive Director of Human Resources for review. The Executive Director, depending on the circumstances, may ask the Department's legal counsel or the Deputy Minister, or both, to review the Declaration. Reviewers may recommend actions to mitigate potential conflicts. A written decision documenting who reviewed the Declaration, and any recommended actions, is prepared and kept on file with the Executive Director of Human Resources, with a copy to the employee. This process was in place during the Executive Director's employment with the Department.

4. Recommendation

4.1 Documenting potential conflicts of interest

Recommendation

We recommend that the Department of Energy follow its own policies and processes by ensuring discussions, conclusions, and actions taken—including the risk-mitigation strategy—when an employee has declared a potential conflict of interest are clearly documented and retained.

Background

The preceding section summarizes the Department's policies and processes for identifying and managing conflicts of interest. This section describes the Department's participation in the EUB hearings (now the responsibility of the Alberta Utilities Commission) for background on the Executive Director's involvement in the hearing.

500 kV line needs identification hearing

Under legislation, the AESO (also known as the Independent System Operator or ISO) is responsible for planning and operating Alberta's electric system. When the AESO believes it is necessary to build more transmission capacity within the Province, it must prepare a needs identification document and submit it to the EUB. In addition to justifying the need for more transmission, the needs identification document includes a number of different proposals for filling the need. The EUB conducts a public hearing where interveners can challenge the needs identification document. The EUB must assess the need and proposed solutions using criteria specified in the legislation and then decide whether to approve the proposal after considering the criteria and evidence submitted during a hearing.

Department wanted to explain transmission policy in public hearing

The needs identification hearing for the Edmonton-Calgary 500 kV line occurred between May 2004 and April 2005. At the end of this period, the EUB issued *Decision 2005–031* in which it approved the AESO needs identification proposal. The Department participated in this hearing and was subject to questioning by other interveners in the hearing. The Department told us it believed it was important to participate so that it could explain and answer questions about the *Transmission Development Policy* and the recently implemented *Transmission Regulation.*

In the past, governments have issued "white papers" as one way to publicly provide background information and rationale for their policies. Rather than issue a "white paper," the Department believed that directly participating in the hearing, where it could be questioned by the EUB and other interveners, was a better way to provide this background information. The Department's October 7, 2004 letter to the EUB requesting intervener status explains this in more detail, and indicates, "The department does not take any particular position with respect to the technical merit of this particular application. The focus of the department's intervention is to ensure that the changes created by the policy and regulation are well understood…"

Review and variance hearing

Following the needs identification hearing, another public hearing, called a review and variance hearing (R&V) was held to give residents living in the corridor (west) where the 500 kV line would be built an opportunity to question the specific routing of the proposed line. In this hearing, a corporate intervener and competitor of the company, which had been directly assigned responsibility for building the line by the AESO after the needs identification hearing, put forth a proposal to build a power line in another corridor (central and east). During the R&V hearing, the Executive Director—on behalf of the Ministry—sent the June 15, 2006 letter.

June 15, 2006 letter

In that letter, the Ministry noted the intervener could have proposed the alternative routing during the needs identification hearing, but did not mention the alternative until landowners had filed for the R&V hearing. The Ministry also expressed concern that time was of the essence and that further delay in constructing the needed transmission line in the province would cost the public money, in terms of line losses[2], and increase the risk of decreased transmission reliability, including the possibility of increased outages. The Ministry therefore urged the EUB to proceed expeditiously. The Ministry did not indicate a preference for routing.

The June 15 letter was consistent with the *Transmission Development The Right Path for Alberta A Policy Paper* submitted by the Department as evidence during the needs assessment hearing in November 2004. In that document, the Department suggested that, for the regulatory process to be efficient, the EUB hearings for the need application, and the approval to construct and operate a new transmission line, should take 6 months respectively. So by the time the June 15 letter was sent, the hearing process was more than a year behind what the Department indicated was reasonable and necessary to bring transmission on line in a timely manner.

Criteria: the standards we used for our audit

- A system should be in place to identify conflicts of interest and resolve them in accordance with the *Code of Conduct and Ethics*.

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[2] Energy waste resulting from the transmission of electrical energy across power lines; usually refers to losses within transmission systems but occasionally refers to the same losses when they occur in distribution systems. These losses occur due to the conversion of electricity to heat and electromagnetic energy. A small amount of loss occurs even in the most efficiently engineered systems.

- Discussions, conclusions, and actions taken to mitigate potential conflicts of interest should be clearly documented and retained.

Our audit findings

The Department met the first criterion, but not the second one. In summary:

- the Executive Director disclosed his potential conflict of interest, thus complying with Section 7 of the Public Service Code.
- the Department's process was not followed because the disclosure and assessment of the Executive Director's circumstances was not done in accordance with the Department's Supplementary Code.
- because of the respective roles and authorities of the AESO, EUB, and the Department, the Executive Director did not have a real conflict of interest.
- although the Executive Director had the ability to influence the Department's submissions to the EUB hearing and the June 15, 2006 letter, we saw no conclusive evidence that he used this influence to benefit himself or his then spouse.
- the balance of evidence led us to conclude the Executive Director did not contravene Section 8 of the Public Service Code by using his influence inappropriately.

Executive Director met *Public Service Code* by disclosing potential conflict of interest

The Executive Director disclosed his potential conflict of interest to the Department both verbally and in writing. The Department's management told us that the Executive Director told to the Deputy Ministers he worked for that his then spouse worked in the industry he had responsibility for. After some searching, Department management found an August 5, 2004 email in which the Executive Director fully disclosed to the then Deputy Minister the nature of a potential conflict and the steps he and his then spouse took to manage potential conflicts. The Department's management told us that the Executive Director continued to inform each Deputy Minister of changes in circumstances affecting the potential conflict of interest throughout the term of his contract, but the Department was unable to provide any other documentation supporting exactly when discussions took place.

We also interviewed the former Executive Director after he left the Department. He indicated that on several occasions he had fully disclosed and discussed his circumstances with both the Deputy Ministers and Ministers that he worked for. The Executive Director indicated they concluded that there was no real conflict of interest, although he and his superiors also considered that there could be an appearance of a conflict of interest. Since the Public Service Code's Section 7 disclosure requirement does not specify the format of disclosure, we concluded that the August 5, 2004 email, along with the verbal representations he made, fulfils the disclosure requirement of the Public Service Code.

Documentation process not followed

However, the Department did not follow its own formal review and documentation process by ensuring that its discussions, considerations, and decision about the Executive Director's circumstances be documented and retained. After sending the email to the Deputy Minister on August 5, 2004 describing his potential conflict of interest, the Executive Director completed the Department's Non-conflict certification form on October 15, 2004 and again on October 1, 2006. Both times he indicated that there were no situations that appeared to result in a conflict of interest. From his perspective, the matter had been disclosed, discussed with management, and concluded on before he completed the Non-conflict certification form. So it seemed unnecessary to repeat the process using the Department's forms. As a result, no Disclosure form was completed. Therefore, the outcome of the Department's review—including the conclusions and proposed actions to mitigate the potential conflict of interest—was not documented.

Although the Executive Director did not complete the Disclosure form because he had already disclosed his circumstances in another way, Department management is responsible for ensuring that potential conflicts are assessed and that the assessments are documented in accordance with the Department's Supplementary Code. Following the documentation process would have ensured that the Department's conclusion—that no real conflict existed—was supported. It also would have ensured that a risk-mitigation strategy to manage the apparent conflict of interest was fully prepared and in place.

No real conflict of interest

The Executive Director did not have a real conflict of interest. The AESO and EUB—not the Department and its staff—propose and approve transmission projects. The former Executive Director had no ability to propose or approve the awarding of the transmission project to the company employing his then spouse. The Executive Director did not decide to send the June 15, 2006 letter to the EUB. The Department gave us a June 2, 2006 email written following a meeting with the president of the company selected to build and operate the 500 kV line. In that email, the Deputy Minister proposed to the Minister sending a letter to the EUB in response to the intervention to consider the central and east corridor. The Minister approved sending the letter, and its contents, and the Executive Director proceeded accordingly.

No inappropriate influence

Elected officials and executive public service managers have significant influence over the development of policy and operations for which they are responsible. However, the combination of influence and an apparent conflict of interest does not automatically create an inappropriate use of influence. We reviewed the Department's submissions to the Needs Assessment hearing and we also reviewed the June 15, 2006 letter. The content of the submissions and June 15, 2006 letter are consistent with the Department's stated objective of clarifying the transmission policy. We found no evidence in these documents that the Executive Director was trying to use his influence to benefit himself or his then spouse. The balance of evidence led us to conclude that he did not contravene section 8 of the Code, which requires employees not to use their position to influence a decision that might further a private interest and to remove themselves from situations where they might further a private interest. This evidence included the facts that the Executive Director:

- fully disclosed his circumstances to his superiors.
- could not directly select the company to operate the 500 kV line.
- wrote the June 15, 2006 letter under the approval of the Ministry.

Implications and risks if recommendation not implemented

An employee's credibility may suffer if Department management cannot show, with documentation, that it assessed the employee's potential conflicts of interest and took appropriate action to mitigate any risks.

Documentation shows whether the process designed to protect the public interest and reputation of the Department and its staff was properly followed. The cost of preparing documentation when the process is followed is minimal compared to the cost of having to justify its absence later.

Implementing the Provincial Mental Health Plan

1. Summary

Mental health is critically important

It is hard to overstate the impact of mental illness on our society. According to recent estimates, one in five Canadians will suffer from mental illness. The burden on those living with mental illness, their families, our economy, and our society matches that of any other illness. However, historically, mental health issues have received little public attention. As well, the approach to dealing with mental health is changing in this country and this province. We are moving from a largely institution-based system to a community-based system that emphasizes an integrated continuum of care from many service deliverers.

The *Provincial Mental Health Plan* is a major step

The *Provincial Mental Health Plan*, released in 2004, represented a major step for Alberta. First, the *Plan* highlighted mental health in a way that hadn't happened before. Second, it achieved the collaboration of numerous Alberta departments, agencies, and boards, plus service providers and stakeholders outside the government family. Third, it presented a vision and priorities that align with the best practices described in authoritative studies such as the federal Kirby report[1]. Fourth, from our work we have seen that a host of mental health initiatives have begun, spurred by the introduction of the *Plan*.

Scope and objective of our work

Our first work in the mental health field[2] focused on the Alberta Mental Health Board (AMHB) and the Department of Health and Wellness. We examined the systems these two entities have to determine whether the *Plan's* implementation priorities[3] are being successfully implemented. The priorities "offer the best opportunities for immediate action and the best potential for considerable improvements in services and supports"[4]. They are critical to implementing the new approach to mental health. As well, participants intend to update the *Plan*, beginning in 2008–2009. We see our work as an input to the next round of mental health planning and implementation.

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[1] The Kirby Report, entitled *Out of the Shadows At Last* (May 2006; pp. 57 and 58), describes principles such as: a focus on patient recovery; a choice of treatment models; community-based services; the integration of services and supports; consideration of the social determinants of health (e.g. housing, income, etc.); evidence-based services. The *Provincial Mental Health Plan* advocates many of these principles.

[2] We are planning a second phase of work that examines the delivery of mental health services in Alberta's regional health authorities.

[3] We list the twelve implementation priorities in Appendix A starting on page 81.

[4] *Provincial Mental Health Plan*, p. 62.

Conclusions

Based on our work, we have seen how the *Plan* spurred activity on mental health issues in Alberta. However, when we focused on the *Plan*'s twelve implementation priorities, we concluded that the first round of planning did not introduce strong systems to plan, monitor, and report their progress. As a result, it is difficult for the AMHB and Department to determine whether the many mental health initiatives now underway amount to successful implementation of the *Plan*. For example, implementation plans for individual priorities were not completed as envisioned in the *Plan*. Most implementation priorities did not have specific deliverables or timelines for completion. Three years after the *Plan*'s release, it is difficult to determine whether the results we now observe are what were originally intended.

Two recommendations

In the second round of planning, the AMHB and Department, supported by other mental health participants, should strengthen their systems for planning, monitoring, reporting, and (if required) adjusting implementation of the *Plan*. As well, the Department should ensure there is a complete accountability framework[5] in place for mental health in Alberta, including a framework to implement the *Plan*. By strengthening these systems, the priorities themselves as well as accountability for implementing them will be clearer. Participants will have systems to identify and support early correction of priorities that do not progress as planned. This is important for a collaborative undertaking like the *Plan*.

2. Objectives and scope

Our audit objective

Our objective was to determine whether the AMHB and the Department of Health and Wellness[6] have systems to determine whether the April 2004 *Provincial Mental Health Plan's* implementation priorities are successfully progressing. This is important because the *Plan* outlines a major policy initiative. In our view, these two central entities are the eyes and ears for the Minister and they need to know how the *Plan* is progressing. By focusing on the *Plan*'s twelve priorities, we developed an insight how overall implementation of the *Plan* is progressing.

Scope statement

For this phase of our audit, we limited our scope to the activities of the AMHB and the Department. We did not examine systems in the RHAs because in this phase of our work we focused on whether the central entities have adequate systems and, as a result, knew about *Plan* progress.

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[5] The *Provincial Mental Health Plan* (p. 14) says that "the accountability framework provides a basis for monitoring progress in implementing the *Plan*, identifying necessary changes and ensuring the fulfillment of mutually agreed roles, responsibilities and performance expectations".

[6] In this document, we often refer to the AMHB and the Department of Health and Wellness as "the central entities".

Timing and extent of audit work

We reviewed systems at the two central entities in the period from November 2007 through January 2008. We limited our procedures to discussion with staff of the entities, review of their documents, and an analysis of the material provided. We did not trace information in those documents to source to ensure they contained complete, timely, and accurate information.

3. Understanding the mental health environment

The impact of mental illness

The prevalence of mental illness

It's hard to overstate the impact of mental illness on our society. According to recent estimates, one in five Canadians will suffer from mental illness. In 2002–2003, over 500,000 Albertans were treated by a physician for a mental health related problem[7]. This represented over 2.25 million visits to a physician and accounted for 39% of all general practice physician billings. Overall, about $472 million in public funding was spent on mental health services, about 7% of the total amount spent on healthcare services in Alberta in 2002[8]. As many as 15% of police contacts are with people with mental illness. Suicide is strongly linked to mental illness and remains one of the leading causes of death in Canada, higher than deaths by homicide or motor vehicle accidents[9].

Aspects of mental illness

Mental illnesses include mood disorders (such as major depression and bipolar disorder), anxiety disorders, concurrent disorders (a mental illness as well as substance abuse), schizophrenia, and eating disorders. Mental illness is often a chronic condition. While mental illness affects both genders and all ages, research shows that some population groups such as children, seniors, and aboriginals may be more vulnerable than others. Due to the nature of their disease, individuals with mental illness often need to deal with related issues such as:

- maintaining employment and a reasonable income level,
- decreased ability to obtain housing,
- high incidence of addiction issues, and
- difficulty with personal and employment relationships.

The issue of stigma

Social stigma associated with mental illness remains one of the major obstacles in addressing mental health issues in the community. Stigma may prevent people from seeking treatment at early stages of the illness. Stereotyping and prejudice by the community reduces the support available for successful recovery and community reintegration. Individuals suffering a mental illness may temporarily lose the ability to advocate for themselves and seek the resources they require for recovery.

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[7] Alberta Mental Health Board, Information Management

[8] Huebner, L., Gardiner, H. & Adair, C. (2002). *Best Practices in Mental Health Systems: An International Review.*

[9] Statistics Canada: 2004 data

Evolution of mental illness treatments

The 20th century witnessed a rapid increase in understanding of, and treatments for, mental illness. Diagnostic capacity, medical procedures, pharmaceuticals, and therapies (individual and group) all developed in a relatively short period of time. A phenomenon of this period was the development of specialized institutions. For serious cases of mental illness, jurisdictions built large institutions like Alberta Hospital Edmonton and Alberta Hospital Ponoka to house their patients. By the second half of the 20th century, most experts advocated a more integrated approach, by which we mean keeping the patient in the community and part of everyday life.

Further references

Mental health is a complex issue. Readers can find a comprehensive review of the Canadian situation in the federal Kirby Report, entitled *Out of the Shadows At Last*[10] (May 2006).

Treating mental illness in Alberta

Kinds of services required

Mental illness treatment and recovery requires a broad range of services. In addition to medical and psychological expertise, patients may also need services such as income support or legal assistance that will come from entities outside the healthcare community. As well, the programs and personnel delivering mental health services need systemic support. This includes human resources (hiring, training, etc.), facility management, data systems, drug management, physician payments, applied research, and more.

Organizations that deliver these services

In Alberta, both private and public entities deliver mental health services (medical and non-medical). Here, we highlight some key contributors. A variety of mental health services and initiatives originate within or through the Ministry of Health and Wellness[11]. Various not-for-profit entities and consumer groups are involved in providing advocacy, program delivery, and policy advice. In the private for-profit sector, mental health services are delivered mainly through employer health benefits plans, private health insurance plans and services obtained privately from mental health professionals (for example, therapy from a private psychologist).

Integration of mental health into general health service delivery

In 2001, the provincial Mazankowski report titled, *A Framework for Reform,* highlighted the need for better integration of mental health services with the rest of the healthcare system, the need for a single point of entry, and more community-based mental health programs. In 2003, the provincial government responded to this shift in thinking about mental health care by transferring most services delivered until that point by the Alberta Mental

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[10] http://www.parl.gc.ca/39/1/parlbus/commbus/senate/com-e/soci-e/rep-e/rep02may06-e.htm

[11] The Ministry includes the following entities that are part of the *Plan*: the Department of Health and Wellness, the AMHB, the nine regional health authorities, and the Alberta Alcohol and Drug Abuse Commission.

Health Board (AMHB) to the regional health authorities (RHAs). This step signalled an emphasis on integrated services in Alberta.

The Alberta Mental Health Board

Until the transfer of services in 2003, the AMHB delivered many mental health services in Alberta. The AMHB now delivers very few services to patients. Its current role is to support the Department with policy research and development; represent the province; liaise, advise, and coordinate with the Department, RHAs, and other stakeholders; and administer defined province-wide mental health programs[12]. The AMHB does this with about 50 employees.

The Department of Health and Wellness

The Department has limited resources dedicated to mental health. There are three employees whose focus is mental health in the Population Health Strategies group. In addition, staff from areas such as funding, information management, and health planning will be involved with mental health issues as required.

The *Provincial Mental Health Plan*

Multiple entities involved in mental health

In the Ministry of Health and Wellness, the Department establishes policy, the AMHB advises the Department and RHAs, and the RHAs deliver services. Other entities, both in the government of Alberta and outside, also deliver services. To move the system to modern integrated views of care and to give general direction, the province developed the *Provincial Mental Health Plan*[13]. It was a major advance for Alberta.

The importance of the *Provincial Mental Health Plan*

The main features of the *Plan* are to integrate mental health into general healthcare while emphasizing the importance of mental health. This may seem contradictory, integrating while emphasizing. However, it is the direction advocated by many in the mental health field[14]. The *Plan* also emphasizes collaboration amongst the many participants and service providers in the community.

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[12] For more information on the AMHB, go to its website: http://www.amhb.ab.ca/Pages/default.aspx.

[13] http://www.amhb.ab.ca/Publications/reports/Pages/ProvincialMentalHealthPlan.aspx

[14] For example, see the Kirby Report already cited.

Confirming our interest in mental health service delivery in Alberta

We surveyed Alberta doctors in January 2008

Through literature review and discussions with stakeholders, we familiarized ourselves with the issues in mental health service delivery. We wanted to confirm that these issues were still relevant more than three years after the introduction of the *Provincial Mental Health Plan*. In January 2008, we surveyed a sample of psychiatrists and other medical doctors practising in Alberta[15]. Alberta doctors, particularly family physicians and general practitioners, are the most frequent initial point of contact with the mental health system. Doctors are also key decision makers when it comes to access to specialists, institutions, and specialized funding and treatment programs. Our survey included psychiatrists, general and family physicians, emergency physicians and others.

Doctors still see major issues in the mental health system

Our survey results indicate that this key service delivery group believes there are still serious issues with the system. For example, only 17% agreed that service delivery in Alberta has improved in the last three years; 44% disagreed with the statement and the remainder were neutral. Only 14% agreed that appropriate community treatment programs are available; 60% disagreed. Only 8% agreed that case management and community follow-up are adequate; 70% disagreed. The results indicate that attaining the vision in the current *Plan* requires further collaborative effort.

4. Criteria and conclusions

Systems can improve for the second round of planning

We found that the AMHB and Department have systems intended to monitor progress on the *Plan's* implementation priorities, but those systems are not well designed and cannot determine whether the *Plan* as a whole has successfully progressed. We made two recommendations that will strengthen systems for the second round of provincial mental health planning[16].

Four criteria

We defined four criteria to guide our work. Our conclusion against each criterion is summarized in the table below. We discuss the reason for each conclusion in the paragraphs that follow the table. These conclusions are supported by detailed discussion of each of the twelve implementation priorities. This detailed work is in the appendix.

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[15] We invited 3,072 physicians to participate in our internet survey; 462 responded. The survey results are accurate to within +/- 4.2% at a 95% confidence level.

[16] When we speak of the second or next round of planning, we assume it will include a post-implementation review of the current *Plan*, then a *Plan* update that will define a new group of implementation priorities. Those updated priorities will again require implementation plans.

For the 12 Implementation Priorities

For the twelve Implementation Priorities, the criteria and our conclusions are:

Criteria	Conclusion			Related Recommendations
	Met	Partially Met	Not Met	
Responsibility for each priority should be clearly assigned to a particular party.		✓		5.1, 5.2
An implementation plan and/or process should be created for each priority.		✓		5.1, 5.2
The two entities should monitor and periodically report the progress of the *Plan*'s priorities.		✓		5.1, 5.2
Action and progress on the priorities should continue to promote the policy direction, collaboration, and momentum generated by the *Provincial Mental Health Plan*.		✓		5.1, 5.2

Assigning responsibilities

Central entities understood who led each priority

We would have expected a summary from the central entities with the priorities listed and responsibilities assigned. The summary would have defined who was responsible for the various stages in the accountability cycle[17]. Such a summary was not created. However, staff at the central entities understood who was in charge of implementing each priority. They were less certain about who monitored, reported, and adjusted each priority or the *Plan* in general.

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[17] We define the accountability cycle on p. 72.

Central entities did not monitor progress on all priorities

For example, although the *Plan* called for implementation plans, written plans were specifically created for only three priorities[18]. The central entities did not monitor the progress of five priorities[19]. As well, the AMHB and Department did not hold the same view of what the AMHB's role should be in monitoring various priorities. Overall responsibility to monitor and adjust progress on the *Plan* itself can be clarified.

Recommendations support the next round of planning

Our recommendations look to the future. When implemented, they will strengthen project management and accountability for the second round of mental health planning and implementation. Recommendation 5.1 deals with the activities and deliverables that need to be completed. Recommendation 5.2 deals with who should be responsible for those activities and deliverables.

Implementation planning

Characteristics of good plans

There are many authoritative sources listing the characteristics of sound implementation or project planning[20]. We highlight these characteristics because the second round of mental health planning can incorporate them:

- Roles and responsibilities should be defined.
- Deliverables should be clearly defined.
- Timelines for deliverables should be established.
- Required resources should be estimated.
- Measures of successful implementation should be created.
- Sign off procedures should be established.

Priorities should be more clearly defined

The *Provincial Mental Health Plan* itself was indistinct about many of its implementation priorities. In the next round of planning, a plan with more clearly defined priorities will be a stronger foundation for success and accountability.

Implementation plans should be stronger

Three of the priorities did generate written plans and four others[21] have documents that outline (after the fact) a successful implementation process. Round two of mental health planning can strengthen these planning processes.

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[18] The transition fund, suicide prevention, and mental health research priorities.

[19] Increasing service capacity, clarifying roles and responsibilities, most of the inter-ministerial priorities, workforce planning, and implementation plans.

[20] Project management practices from the Project Management Institute are one example.

[21] Review of regional mental health plans, funding methodology, public education and awareness, and information requirements and performance measures.

Monitoring and reporting progress

To monitor and report the progress of the *Provincial Mental Health Plan* requires two interrelated processes: the first is to monitor and report progress for each of the twelve implementation priorities; and because the *Plan* is more than the twelve priorities, the second process is to monitor and report results for the *Plan* in total.

Some priorities not centrally monitored

With work on twelve priorities underway, there is a great deal of work to be monitored. Where the AMHB or Department is the co-lead on a priority, there is information available. Where they aren't, there's much less central monitoring and information. We did not see evidence of routine monitoring for five[22] of the priorities.

Limited reporting on the progress of the *Plan* in total

The *Plan* itself calls for a review after three years. The AMHB will lead it, but not until 2008–2009, about a year behind schedule. The various initiatives and priorities in the *Plan* have taken longer to roll out than anticipated, thereby delaying the review. In addition to the three-year review, the AMHB creates a "Quarterly Performance Report" that goes to the Department for review. Portions of those reports touched on *Plan* implementation. New for 2007–2008, the report requires a "status report on RHA implementation of the PMHP"; while an annual requirement, the first status report is not due until June 30, 2008.

Policy direction, collaboration, and momentum

We saw evidence of progress in many areas

We acknowledge the work is progressing on many fronts. The central entities can point to actions in most priorities. So the *Plan* focused attention and spurred activity on mental health issues in Alberta. The activities we reviewed promote the policy direction and continue the collaborative approach that is critical to the *Plan*.

Stakeholders may not be able to see that progress

However, we can make these comments because we spent time at the central entities. Stronger accountability for the completion of the twelve priorities is required to demonstrate and encourage momentum for participants and stakeholders.

The risk that *Plan* momentum may fade

More importantly, there is a risk that momentum generated by the creation of the *Plan* may fade. When mental health services were transferred to the RHAs in 2003, the Ministry of Health and Wellness was concerned that RHAs' other healthcare responsibilities may overshadow its new mental health component. To counterbalance, mental health needs to be kept on the service delivery radar. The *Plan* and its implementation priorities help to maintain mental health's profile.

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[22] Increasing service capacity, clarifying roles and responsibilities, most of the inter-ministerial priorities, workforce planning, and implementation plans.

We are concerned that the drive to keep mental health on the radar may be fading. We will take one example only. As directed by the *Plan*, RHAs developed region-specific mental health plans for 2005–2008; this was a major undertaking for the RHAs. They created these mental health plans once only; since then regional mental health planning has been absorbed into the RHAs' general health plans. The RHAs need to integrate mental health into the general health service delivery and cannot support a major mental health planning initiative every year. However, mental health planning at the regional level now consists of a small component in very large health plans. In addition, the RHAs have not reported against their 2005–2008 mental health plans. It appears the planning momentum generated in 2005 may have faded over three years.

5. Recommendations

5.1 Implementation systems

Recommendation No. 3

We recommend that the Alberta Mental Health Board and the Department of Health and Wellness, working with other mental health participants, strengthen implementation of the *Provincial Mental Health Plan* by improving:

- **implementation planning,**
- **the monitoring and reporting of implementation activities against implementation plans, and**
- **the system to adjust the *Plan* and implementation initiatives in response to changing circumstances.**

Background

Answering for one's assigned responsibilities

We define accountability as the obligation to answer for the execution of one's assigned responsibilities. To be accountable, entities should follow the cycle of:

- planning what needs to be done to achieve goals, including setting specific deliverables, timelines, and responsibilities,
- doing the work,
- monitoring progress against the plans and reporting the analysis to those responsible, and
- evaluating progress and adjusting plans and actions as required.

The two entities anticipate another round for the *Plan*

The *Provincial Mental Health Plan* outlines the final outcomes that the government and participants want to see regarding mental health. In this sense, it is primarily a policy document. It contains general definitions of the twelve implementation priorities. We understand that it was always the intention of the AMHB and Department to complete a three-year review of *Plan* implementation and then develop a second round of implementation.

Criteria: the standards we used for our audit

Responsibility for each priority should be clearly assigned to a particular party. An implementation plan and/or process should be created for each priority. The two entities should monitor and periodically report on the progress of the *Plan*'s priorities. Action and progress on the priorities should continue to promote the policy direction, collaboration, and momentum generated by the *Provincial Mental Health Plan*.

Our audit findings

The *Plan* as a foundation for action and accountability

The *Provincial Mental Health Plan* primarily outlines policy direction. As a planning tool, the *Plan* is not a strong foundation for action and accountability. The *Plan* is not clear on what should be accomplished in what timeframe. Three years later, this shortcoming makes it hard to assess whether the many initiatives undertaken amount to successful implementation of the *Plan*. The *Plan* itself hardly touches on the process to monitor and report progress. One ramification is that we saw no indication of remedial actions to address priorities that are moving slowly. We report these findings with the expectation they can be corrected in the next round of mental health planning. We understand the next round will begin with the current *Plan*'s post-implementation review in 2008–2009.

Planning

Priorities in the *Plan* did not define clear tasks

Our appendix gives the full wording from the *Plan* for each implementation priority. These descriptions do not define specific deliverables, timelines, and measures, so they are not clear tasks in a project management sense. We can take timelines as an example. In a multi-year plan, it is essential to have a view of completion dates. Yet some of the priorities only require that participants "begin" the priority. Looking to the next round of provincial mental health planning, *Plan* writers should define clear tasks whose progress can be planned, monitored, and reported.

Resources often dictate the success of new initiatives

The *Plan* does not have its own funding to support change. As an observation from our work, progress on a priority is dependent on money and resources. The Innovation Fund projects are an example. With $75 million of new money, 36 projects can move ahead. However, after the three years of Innovation Funding, some of those projects may be at risk. We reviewed five project progress reports from the RHAs. Although the five projects are progressing successfully, one RHA reported it may not have the funding to continue its project after Innovation Funding expires.

Planners need to prioritize with resources in mind

The group accountable for refreshing the next *Plan* should consider resources at the time they set their priorities. Some priorities can be advanced with existing money and resources. For those priorities that require new or redistributed funding, the planners should carefully prioritize. This should minimize the number of priorities at risk due to lack of resources.

Implementation plans are required

Because the current *Plan* is primarily policy direction, it correctly required individual implementation plans for each priority. Documented plans were created for three priorities[23]. In a collaborative environment where implementation is the responsibility of several parties, implementation plans need to provide clear direction, clarity of roles, and a foundation for monitoring, reporting, and analyzing progress. In the next round of planning, participants should create implementation plans for each priority.

No system to approve implementation plans

The next *Plan* should also define how to bring these implementation plans together for review and approval by an appropriate body or entity. This system increases the integration of planned work and reinforces the accountability cycle.

The *Plan* did not create a system to monitor progress

The current *Plan* does not address ongoing monitoring, reporting, and adjusting based on progress analysis. It requires a post-implementation review after three years, but it is silent on monitoring in the interim. For the next planning cycle, participants should include an ongoing monitoring, reporting, and adjusting system. This includes identifying the group or entity to perform and enforce the reviews and resulting decisions (see recommendation 5.2 on page 77).

Monitoring and reporting individual implementation priorities

Participants did not monitor progress against plans

Only three priorities had a documented implementation plan. One of those plans[24] is not yet approved by its oversight committee. So in most cases, the ability to monitor against an implementation plan is not possible. Even for those with written plans, monitoring and reporting against those plans does not happen.

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[23] The transition fund, suicide prevention, and mental health research priorities.

[24] For the public education and awareness implementation priority.

All priorities should be monitored

In general, the AMHB or Department monitor the priorities in which they directly participate either as a lead or as a member. In these cases, the central entities participate on steering groups, meet their partners frequently, and discuss ad-hoc issues. However, where other parties lead a priority, the AMHB and Department know much less about progress. For example, the general health workforce planning process absorbed the mental health workforce planning exercise. The AMHB and Department could not tell us whether the mental health workforce concerns expressed in the *Plan* have been addressed by the general workforce planning process. This is true for the service capacity and elements of the inter-ministerial priorities as well. The central entities need to monitor whether all mental health priorities are making progress against the initial *Plan* objectives.

AMHB's quarterly reports gave some view of progress

As mentioned, the AMHB does a "Quarterly Performance Report" against its "Multi-Year Performance Agreement". Each report goes to the Department for review. We reviewed the past two years' reports and found that they do not specifically comment on the twelve priorities. The reports list the AMHB's own actions in the areas specified in that year's "Performance Agreement" with the Minister of Health. As many areas correspond to priorities (e.g. research, suicide prevention, and others), there is a hint of progress reporting for some of the priorities. However, the reports do not directly monitor and report on the twelve implementation priorities.

Monitoring and reporting the *Plan*

An ad hoc request for a progress report in 2006

We learned of two initiatives that monitor progress on the *Plan*. The first was a written request in 2006 from the Deputy Minister of Health to the Chief Executive Officer of the AMHB to report on transition to AMHB's new mandate. The report from the AMHB listed numerous activities, in the course of which many *Plan* initiatives were covered. However, some priorities were not addressed and the report does not specifically deal with whether *Plan* progress has met expectation.

An annual reporting requirement starting in 2007-08

Second, the AMHB's "Quarterly Performance Report" requires a "status report on RHA implementation of the PMHP". The first full report is due June 30, 2008 and annually thereafter. However, reporting by quarter so far has listed AMHB rather than RHA activities, by and large. The report contains a lot of detail (indicating activity) but no comparison to expectation (which would fulfill accountability). As well, RHA implementation is only a part of the overall implementation of the *Plan*.

Three-year review of the *Plan*

There is, imbedded in the *Plan* itself, the requirement for a three-year review led by the AMHB. They're behind on this because *Plan* implementation has taken longer than expected and because of work on other major initiatives in the past year (for example, a province-wide mental health Bed Review). To date, there has been no reporting to participants in the *Plan* or to the public on implementation progress.

Routine reporting should be established

The next *Plan* should define a regular regime of monitoring and reporting. The regime should enable participants to judge progress against the *Plan*. Our second recommendation discusses who should receive reports and for what purpose.

Adjusting activities based on progress

No system to adjust activities based on progress

A major reason for monitoring and reporting is to support the system to adjust plans based on progress. We did not see that such a system now exists. Especially at the *Plan* level (as opposed to the priority level), it is not clear who has the authority or influence to compel adjustments even if progress suggested adjustments were necessary. For the next planning cycle, participants should create a system that includes this accountability element.

Implications and risks if recommendation not implemented

Without a documented implementation planning system (especially in a collaborative field like mental health), there is a risk that:

- Deliverables, timelines, targets, and resourcing may not be established;
- Activities may not be coordinated;
- There may be no foundation for monitoring and reporting priorities for the *Plan* as a whole;
- It may be difficult to determine whether progress is being made.

Without monitoring the implementation of such a large undertaking, it's possible that priorities may not be actioned or unfold as planned. As well, those responsible will not have a system to alert them to issues that require remediation. Without a system of remediation, momentum on *Plan* implementation may stall.

Planning, monitoring, reporting, and remediation systems should be in place for the second round of the provincial mental health initiative. Without stronger systems, the momentum generated by the first round activities may be lost.

5.2 The accountability framework

Recommendation No. 4

We recommend that the Department of Health and Wellness ensure there is a complete accountability framework for the *Provincial Mental Health Plan* and mental health services in Alberta.

Background

Assessment required after three years

The *Provincial Mental Health Plan* (p. 14) says that "the accountability framework provides a basis for monitoring progress in implementing the *Plan*, identifying necessary changes and ensuring the fulfillment of mutually agreed roles, responsibilities and performance expectations".The *Plan* also requires an assessment of implementation progress and identification of changes necessary to the *Plan* within three years of its release.

Many committees involved in *Plan* implementation

Many committees with membership from the organizations involved with mental health have been established to implement *Plan* priorities. Participation on the committees varies depending on the purpose of the committee.

Performance agreement between the Minister and the AMHB

The AMHB has its "Multi-Year Performance Agreement" with the Minister of Health. The AMHB prepares and forwards to the Department its "Quarterly Performance Report" that summarizes its progress, organized in the same format as the "Agreement". One performance measure (i.e. task) in the "2007-2008 Agreement" is an "annual status report on RHA implementation of the *Plan*".

Criteria: the standards we used for our audit

Responsibility for each priority should be clearly assigned to a particular party. An implementation plan and/or process should be created for each priority. The two entities should monitor and periodically report on the progress of the *Plan*'s priorities. Action and progress on the priorities should continue to promote the policy direction, collaboration, and momentum generated by the *Provincial Mental Health Plan*.

The underlying principles in this section are:

- accepting responsibility for an activity and its deliverables,
- having the authority to implement the activity, and
- being accountable for its execution.

Our audit findings

Our work on the *Plan* also furnished a view of overall mental health accountability in Alberta

Our work focused on the *Plan* and our findings illustrate the accountability framework issues for the *Plan*. Our work also provided insights into the current accountability framework for mental health in Alberta. For example, we reviewed the AMHB's "Quarterly Performance Reports", the annual health plans and reports from the RHAs, and the work of several committees. Clearly, implementing the *Plan* is only one aspect of mental health services in Alberta. When the Department considers the accountability framework for the *Plan*, it will also be appropriate for the Department to consider the framework for mental health services in general. The *Plan* states that the Department is responsible for "defining and managing the accountability framework for mental health" (p. 14).

Accountability for progress of the *Plan*

The *Plan* was a collaborative effort with no clear owner

The *Plan* was the result of a collaborative effort by many organizations involved with mental health in the province. No one clearly owns the *Plan*. For example, the document itself does not feature a Minister or Deputy as sponsor while considerable emphasis is placed on collaboration throughout the document. For those reasons, it is not clear who is accountable for its implementation or reporting progress.

The Department should define the accountability framework

The *Plan* specifies that the Department should define and manage the accountability framework for mental health. Looking forward to the next round of planning and implementation, the Department should establish what entity or group has the authority to be accountable for *Plan* implementation. Given the collaborative nature of the *Plan*, a group may be appropriate. In other inter-ministerial initiatives, groups of Deputy Ministers, Assistant Deputy Ministers, or senior civil servants play this role. Whoever the accountable group, they should clearly understand and accept that authority and accountability. Some of the duties that this group could play are outlined in the previous recommendation.

Currently the AMHB monitors RHA progress

The AMHB has been assigned the task of monitoring RHA progress against the *Plan*. However, RHA progress is only a portion of all progress against the *Plan*. The AMHB's quarterly report goes to the Department. It is not clear that either the AMHB or the Department, neither of whom deliver the bulk of mental health programs, has the authority to act on findings from those reports. Reporting progress for the *Plan* should be regular and should go to participants involved in implementation. Similarly, a regular public reporting system should be considered.

Accountability by working groups

The need for clear accountability applies at the priority level

As we outline in our appendix, many committees have been formed to support implementation of the *Plan*'s priorities. But in many cases, their mandates are vague, using terms such as oversight, support, provide input, share information, advance goals, work collaboratively, lead, or assist.

The same principles that apply to overall *Plan* accountability should apply for each priority's accountability. For priorities that require multi-entity collaboration, accountability should be clearly assigned and accepted.

Accountability for the RHAs

The AMHB cannot be accountable for the RHAs' activities

There is an implementation priority to "take steps to clarify the roles, responsibilities and working relationships between regional health authorities and the Alberta Mental Health Board". This wording does not specifically cover accountability. At any rate, the AMHB cannot be accountable for the activities of the RHAs. So there may be a need to form a group to exercise accountability for RHA implementation of *Plan* priorities.

The relationship between the AMHB and the RHAs may need to be clarified

We did not canvas the RHAs to get their views on their relationship with the AMHB. Looking to the next round of planning, participants should consider whether the respective roles and relationships between the AMHB and the RHAs are clearly understood. If they are not, a clearer priority describing the activities, monitoring, and reporting to be undertaken by which parties will be appropriate.

AMHB accountability to the Department

The two entities should agree on the AMHB's role in *Plan* accountability

There is a difference of opinion between the AMHB and the Department in the way they view accountability for priorities. We can explain this with an illustration. A priority will often say, "The AMHB and RHAs should work together ..." or "The AMHB, in participation with the RHAs, and in collaboration with the Department ...". The AMHB interprets this to mean they will lead a collaborative effort; they don't see themselves in charge. Because they do not have sole authority for the priority, they work collaboratively to achieve the priority. When the Department reads those words in a priority, they believe the AMHB is in charge and responsible for its implementation This difference needs to be resolved.

The AMHB's reporting to the Department can improve

We described the "Multi-Year Performance Agreement" between the parties, supported by quarterly reporting. That process can improve, as illustrated by the reporting on the "RHA implementation" measure. For that measure, the AMHB lists numerous activities in its report and grades its expectation assessments as "Met". Staff at the Department review the reports and file them away. However, the reports mainly describe AMHB rather than RHA activity, and there is no mechanism to analyze how or whether expectations have been met. As an accountability process, it can be strengthened. Further clarity in the relationship would be beneficial to the future implementation of the *Plan*.

Implications and risks if recommendation not implemented

Without the same understanding of each entity's roles and responsibilities, it's possible that activities may not progress or be adequately monitored and reported.

Appendix A—Summary of findings on the Provincial Mental Health Plan's implementation priorities

Appendix A—summary of findings on the Provincial Mental Health Plan's implementation priorities

Summary results

Implementation Priorities	Criteria			
	1 Responsibility	2 Implementation planning	3 Monitoring & reporting	4 Policy direction, collaboration, & monentum
Regional MH plans	Met	Met	Met	Partially met
Increase service capacity	Not met	Not met	Partially met	Partially met
Transition fund	Met	Met	Met	Met
Funding methodology	Met	Met	Met	Met
Clarify roles & responsibilities	Partially met	Not met	Partially met	Partially met
Inter-ministerial priorities	Met	Not met	Partially met	Partially met
Public education & awareness	Met	Partially met	Partially met	Met
Suicide prevention	Met	Partially met	Met	Partially met
MH workforce plan	Met	Met	Partially met	Partially met
MH research plan	Met	Met	Met	Met
Info requirements & measures	Met	Met	Met	Partially met
Implementation plans	Not met	Not met	Not met	Not met

Summary				
Met	9	6	6	4
Partially met	1	2	5	7
Not met	2	4	1	1

Priority-by-priority analysis

On the following pages, the description within each box is taken verbatim from the *Provincial Mental Health Plan*, pp. 62 and 63. After each box we summarize the activities that have taken place over the past three years since the release of the *Plan*. We then conclude whether each of our four criteria have been met for each priority.

We encountered two challenges in doing this work. First, the priorities are sometimes narrowly written; for example, the first priority says that RHAs "should begin work immediately". At the end of three years, we expected more would have been accomplished on regional mental health plans than simply "beginning work". In some cases, there is a broader description elsewhere in the *Plan* to indicate where the priority should be headed. For example, the workforce planning priority is discussed in the chapter on human resources (pp. 43 through 49). This emphasizes the need for priority-specific implementation plans.

Second, for some priorities we had to establish an expectation for the AMHB and Department's participation in the priority. For example, the first priority calls for RHAs to create mental health plans. The AMHB and Department's role would be to support that work by review and feedback.

> **Develop regional mental health plans.** Within the scope of this provincial plan, regional health authorities should begin work immediately on identifying priorities, service gaps and regional mental health plans.

Summary

Every RHA prepared a three year Regional Mental Health Plan for 2005-08. The plans were reviewed by the AMHB and Department, returned to the RHAs for improvements, reviewed again, and subsequently approved by the Minister of Health and Wellness. After the first year, RHAs did not prepare separate mental health plans; mental health was included in each RHA's annual health plan. Each year from 2006–2009 onward, Department and/or AMHB staff have reviewed the mental health elements in each RHA's final health plan. The Department now prepares the final report on each RHA's health plan. The timing of the review can change from year to year. For the review of 2008–2011 health plans, the Department moved the review earlier, to December 2007. The AMHB was not able to participate because they could not respond to the timing change on short notice.

The RHAs have not reported against their 2005–2008 regional mental health plans. The Department's annual instructions to RHAs on creating regional health plans have suggested that RHAs report progress on their 2005–2008 plans. Neither the Department nor AMHB reviews RHA annual reports to ensure this has been done.

Conclusions

The first three criteria were met. Responsibility for reviewing and approving RHA mental health plans (and later the mental health component of health plans) was clearly assigned. There was a clear process to perform the review.

The fourth criterion was partially met. Creation of the regional Mental Health Plans highlighted the mental health agenda in each region. Review by the AMHB and/or Department ensured consistency with the *Plan*. However, the following factors reduce the spotlight effect:

- Moving from regional mental health plans to a single component in a health plan. While this change further integrates mental health into each RHA's business, it may also decrease attention on mental health issues. The risk is that the mental health initiative begun by the *Provincial Mental Health Plan* may be overshadowed by the concerns of general health service delivery.
- RHAs were not required to report against their 2005–2008 regional mental health plans.
- No AMHB participation in the review of 2008–2011 health plans.

Increase the capacity to deliver mental health services and address critical gaps. There is little doubt that the number one priority must be increasing capacity, addressing gaps in services and improving access to essential mental health services. Major gains in improving access and expanding services will depend on the availability of resources but regional health authorities should begin immediately to identify resource needs and actions they can take without additional funds.

Summary

The RHAs implement this priority. We had expected the AMHB and/or Department to monitor progress by the RHAs against this priority. However, both the AMHB and the Department told us they had no role and did not know what the RHAs had done. The two central entities keep in touch with RHA progress through:

- The Department and/or AMHB's review of regional health plans;
- Participation on the Mental Health Network. Members from the RHAs, the AMHB, and other stakeholders comprise this provincial group. It provides a forum to discuss implementation of the *Provincial Mental Health Plan*.
- Ad hoc requests from the regions about implementing this priority.

Conclusions

We expected the central entities to monitor RHA initiatives to increase capacity and address gaps. The first two criteria were not met because the AMHB and Department did not feel they had a role to play. We note that the *Plan* indicates the AMHB should "measure progress in implementing the *Provincial Mental Health Plan*" (p. 16).

The third criterion was partially met. The AMHB and Department monitor RHA progress to some extent through the mechanisms listed above. However, this is not a systematic, province-wide approach. For example, the RHAs' health plans are reviewed, but their reports are not. There may be a difference between what was planned and what was implemented. The fourth criterion is partially met. Many regional initiatives have gone forward but there is an opportunity for further province-wide coordination or sharing information about these initiatives.

Establish a transition fund. To begin implementation of the new directions set in this provincial policy and to build a bridge from old funding models to a new funding framework, a transition fund is essential.

Summary

In 2005, the AMHB and RHAs estimated they needed about $97 million for this program. The Department announced $75 million in 2006, the money to be distributed over three years. The AMHB processed the RHAs' applications and the Department began distributing money on 36 approved projects, starting in 2006–2007. All projects are 3-year (with one exception, which is a one-year project). The AMHB reviews and evaluates progress on individual projects every six months. All projects have acceptable progress.

Conclusions

All four criteria were met. Some RHAs are concerned that they will not be able to extend their Innovation Fund programs past the three year window. They may not have resources to continue the projects.

Develop a new funding methodology for mental health. A new funding formula, specific to mental health needs and priorities, will take time to develop. Work should begin immediately on developing a new population-based funding formula for mental health, including appropriate mental health need-based modifiers.

Summary

The Department implemented the new methodology for calculating the mental health component of RHA Global Funding for 2007-2008. The previous methodology maintained the proportion by region that had been established when the AMHB operated mental health programs. The Department led the Funding Methodology Working Group in developing the new methodology. It is population-based (like the other elements of Global Funding) with specific mental health needs-based modifiers. It contains a no loss provision to maintain each RHA's allocation at least at the previous year's level. Import/export calculations are included in the calculation. The Department describes the new methodology in its annual *Methodology and Funding Manual* (2007/2008, p. 21).

Conclusions

The four criteria were met. We note that the no-loss provision significantly adjusts the results of the population-based methodology back towards the previous methodology's result. As well, participants still need to address the other "funding principles" outlined on pages 37 and 38 of the *Plan*. These include principles such as "predictable, sustainable" provincial allocations, and funding within regions and inter-regionally.

> **Take steps to further clarify the roles, responsibilities and working relationships among regional health authorities and the Alberta Mental Health Board.** This Plan envisions new roles and relationships between regional health authorities and the Alberta Mental Health Board. As a first step in this process, the Alberta Mental Health Board and regional health authorities should work together to further clarify their respective roles and responsibilities, to build positive working relationships and trust at every level in the system, and to advance mental health as outlined in this Plan.

Summary

One could argue that there is no clear deliverable from this priority. If there was a task to be completed, we expected a process between the AMHB and the RHAs that would lead to a document "to further clarify their respective roles and responsibilities". We did not see that such a process took place or a result reached. However, there are other actions related to roles and responsibilities.

The 2007–2010 "*Multi-year Performance Agreement*" between the Minister of Health and Wellness and the AMHB sets out the high level responsibilities of the AMHB. The "Agreement" requires the AMHB to:

- prepare a status report on the RHAs' implementation of the PMHP,
- support, in partnership with authorities and other ministries, initiatives to advance children's mental health, and
- seek opportunities to foster key relationships with key stakeholders, including RHAs, to advance mental health in Alberta.

Working relationships between the Board, RHAs and other stakeholders are facilitated by:

- The Provincial Mental Health Network.
- Many working committees with AMHB and RHA staff that address specific issues. Several of the committees have been established since the release of the PMHP.

The AMHB and/or Department reviewed the regional mental health plans prepared by the RHAs, as outlined for the first implementation priority.

Conclusions

The first criterion has been partially met as the AMHB and RHAs are specified in the priority's description. However, it is not clear what role the Department should play. The Department's responsibilities, as described on page 14 of the *Plan*, include "managing the accountability framework", one component of which is "ensuring the fulfillment of mutually agreed roles, responsibilities and performance expectations".

The second criterion has not been met as there is no implementation plan. As well, we did not see a final document that sets out the working relationship between the Board and the RHAs.

Although measuring progress against a non-existent plan is impossible, the third criterion has been partially met as processes exist to build working relationships between the AMHB and RHAs. For example, the entities cooperate on a number of committees. Because there is evidence of cooperative effort, we conclude that the fourth criterion is partially met.

Take action on key inter-ministerial priorities. Although responsibility for these areas extends beyond the health care system, a number of critical areas have a direct impact on mental health services and supports. In particular, action should be taken to:

- Follow through on initiatives related to children's mental health.
- Take a proactive and coordinated approach to address a broad range of housing needs from affordable housing in the community to safe and supportive housing for people with mental illnesses.
- Explore ways of ensuring that people with mental illnesses who are unable to work have an adequate income to pay for the basic necessities of life.
- Make coordinated and concerted efforts to address issues related to Aboriginal health in general and Aboriginal mental health issues in particular.

Summary

The Department and AMHB share the lead responsibility for children's mental health. They co-chaired the "Positive Futures Implementation Plan Task Group" which developed the implementation plan for the children's mental health framework in conjunction with Children's Services and other ministries. In addition, children's mental health intersects with other mental health initiatives. For instance, the AMHB leads the provincial initiative that developed the Alberta Suicide Prevention Strategy which included children. The AMHB also chairs the provincial group developing access standards for children's mental health.

As opportunities arise to promote mental health concerns, the Department meets with the ministries who have mandates for housing and income support initiatives. The Department provides advice and feedback while the ministry directly responsible takes the lead and are responsible for specific actions. For example, the Department provided advice and feedback to the Alberta Affordable Housing Task Force established by the Minister of Municipal Affairs and Housing, and to Seniors and Community Supports which has responsibility for supportive housing[1]. The Department will meet with Assured Income for the Severely Handicapped (AISH) program managers to explore ways to serve AISH recipients with mental illnesses better.

The AMHB advocates for mental health but does not take a direct role in housing and income support initiatives.

The AMHB has responsibility for Aboriginal mental health as one of the four provincial programs it retained following the transition in 2003. The AMHB oversaw the development and release of "Aboriginal Mental Health: A Framework for Alberta" in 2006.

Conclusion

The first criterion is met. The Department and AMHB share responsibility with other ministries such as Children's Services for action on children's mental health initiatives. The AMHB is responsible for Aboriginal mental health initiatives. Employment, Industry and Immigration is responsible for income support and Municipal Affairs and Housing is responsible for housing.

The second criterion is not met as there were no implementation plans created as a result of this priority. We also understand that the four inter-ministerial initiatives themselves did not change their processes as a result of this priority.

The third criterion is partially met. Although it is not possible to monitor progress against an implementation plan, the AMHB monitors and reports children's mental health and aboriginal mental health initiatives through their quarterly reports. Although the Department participates on committees with the departments dealing with income supports and housing, there is no reporting of the results of that work in relation to the *Plan*. In general, reporting is limited to initiatives that the AMHB is responsible for.

The fourth criterion has been partially met. Quarterly performance reporting by the AMHB highlights the initiatives undertaken for children's and aboriginal mental health issues since the release of the *Plan*. We could not determine whether the

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[1] This is housing mainly occupied by tenants who require support services to live independently in the community.

Plan positively influenced these initiatives or whether these results would have happened in the course of the initiatives. We have not seen documentation which indicates the progress made on housing and income support since the release of the *Plan*.

Expand public education and awareness with the public and within health regions to address the stigma associated with mental health. This is not a short term strategy. In the longer term, significant improvements in services and outcomes for people with mental illness will not be achieved unless the stigma of mental illness can be reduced or eliminated. Efforts should be directed not only to the general public but also within health regions where important steps can be taken to improve the way people with mental illness are treated in the health system.

Summary

The Mental Health Promotion Committee, chaired by the AMHB with representatives from the nine RHAs, coordinates and plans provincial public education campaigns and prevents duplication of initiatives across the regions. The regions' representatives identify needs and issues relating to mental health for their populations and advise what strategies may work. The AMHB takes this information and develops materials and activities for coordinated distribution province wide, with dissemination and implementation handled at the local level by the regions. The Committee also works with the Department to obtain funding for new initiatives. The Board provides evaluation tools for each campaign; RHAs gather the evaluation data which the AMHB summarizes and analyzes. Each initiative is monitored this way.

Conclusions

The first criterion was met because the AMHB and the RHAs take the lead and have formed the Committee to guide this priority. The second and third criteria are partially met. The Committee did not create an implementation plan, although they meet to analyze and decide on initiatives. The AMHB and Committee are working to finalize a long-term, documented strategy to guide promotional activity. This strategy remains a work in progress in January 2008. The AMHB cannot monitor against an implementation plan, but each initiative under this priority is monitored and there is some reporting of progress in the AMHB's quarterly reports to the Department. The fourth criterion is met because we have heard of at least 18 new initiatives implemented over the last three years.

Take immediate action to establish a province wide suicide prevention strategy. Suicide is a serious problem in Alberta and work should begin immediately on a province-wide suicide prevention strategy targeted at the general population, school aged children and vulnerable populations, especially Aboriginal youth.

Summary

The AMHB led the collaborative Alberta Suicide Prevention Strategy Working Group that created "A Call to Action: The Alberta Suicide Prevention Strategy"[2] in 2005. The next step was to create an implementation plan for the "Strategy"; the plan was originally targeted for completion in 2006–2007. The Alberta Suicide Prevention Advisory Committee oversees plan development. The implementation plan was drafted in June 2007 and awaits approval by the Committee as at December 2007. Nevertheless, the Committee, the AMHB, and the Department proceeded with individual initiatives as funding became available. For example, the Department made $12 million of new funding available in 2006 for three children's suicide prevention programs. Progress on other initiatives in the "Strategy" awaits further funding and resource capacity in the RHAs to deliver the programs.

Conclusions

The first and third criteria are met. The AMHB leads the priority, monitors progress on initiatives, and reports progress in its quarterly reports to the Department. The second and fourth criteria have been partially met. The implementation plan for the "Strategy" is not finalized. We also note that the plan itself can improve by defining deliverables more clearly, setting out timelines for each deliverable, and providing a budget. Despite initiatives that have moved forward, it is possible that momentum on this priority may be at risk. The AMHB tells us that without additional funding provided specifically for suicide prevention, RHAs cannot commit to specific prevention efforts.

Develop a comprehensive mental health workforce plan. To address the serious shortage in mental health care professionals and workers, work should begin immediately on a comprehensive workforce plan designed to ensure adequate staffing for the future.

Summary

No work was done on a mental health-specific workforce plan. Right after the *Plan* was released, the mental health workforce planning initiative stopped because participants accepted that an existing general health workforce planning process would cover this priority. The AMHB had input to the process as it is a "region" in provincial terminology. However, neither AMHB nor Departmental mental health staff worked on, monitored the progress of, or reported on the health workforce planning initiative. The general health workforce plan was issued for the period 2007-2016[3]. While there are no specific mental health initiatives listed in the plan, it seems to cover (at a high level) most of the workforce concerns outlined in the *Plan*. The one exception is the fifth strategy related to "the capacity of self-help groups, families and communities" (p. 49 of the *Plan*).

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[2] http://www.amhb.ab.ca/Publications/reports/Documents/AMHB_SPS_mainMar06.pdf

[3] http://www.health.gov.ab.ca/key/Workforce_report07.pdf

Conclusions

We conclude that the first and second criteria are met. The health workforce planning initiative clearly took responsibility and had a plan. The third and fourth criteria are partially met. The process and results are no longer mental health specific. In itself, this may not be critical. However, neither the AMHB nor Departmental mental health staff can tell us whether the general health workforce results satisfy the *Plan*'s original concerns. As well, we found no further work on the "capacity" strategy mentioned in the previous paragraph.

Initiate the development of a mental health research plan. This Provincial Mental Health Plan highlights the critical role of research in improving outcomes and services in mental health. The Alberta Mental Health Board should begin a collaborative process to develop a comprehensive mental health research plan along with plans for establishing a dedicated fund for mental health research.

Summary

The AMHB led a collaborative working group to create "A Plan For A Mental Health Research Program for Alberta" (Feb 2005)[4]. To implement this plan, the AMHB chairs the Mental Health Research Partnership Committee; this began in fall 2005. The research program now has a "Three Year Business Plan: 2007-2010". As funding is secured, components of the business plan are implemented. The AMHB re-allocated money from its current budget to provide what is now the largest source of research funding and is trying to obtain commitments from stakeholders. The majority of the required budget to action the business plan is still unfunded. Progress on approved research activities is monitored by the Committee and AMHB.

Conclusions

All criteria were met. We note that implementation progresses as monies are raised. Given uncertain funding, the risk increases that research goals may not be met due to a lack of resources.

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[4] http://www.amhb.ab.ca/Publications/reports/Pages/PlanforaMentalHealthResearchProgramforAlberta.aspx

Identify critical information requirements and performance measures. To assess progress in implementing this Provincial Mental Health Plan and to measure performance and outcomes on an ongoing basis, considerable work is needed to identify critical information requirements and a minimum data set for mental health.

Summary

We considered both elements of this priority: the identification of mental health information requirements and the development of the mental health performance measurement framework.

Work on information requirements and data sets started before the 2003 divestiture and have been part of the ongoing effort of the Provincial Mental Health Information Management Committee. As a result of the *Plan*, the Department set up the Mental Health Reporting (MHR) Initiative with oversight from the MHR Working Group and MHR Steering Committee. Both are co-chaired by Department staff and include representatives from the AMHB and the RHAs. The Initiative is expected to provide a single site for the regions to send required data starting in April 2009. In 2006-07, the MHR Working Group articulated the mental health information requirements, which were finalized and accepted by the MHR Steering Committee in July 2007.

The performance management framework for mental health was introduced in 2006 by the AMHB, with input from the Department and other stakeholders. The framework[5] includes a list of specific measures. Baseline levels need to be established for the identified measures.

Conclusions

The first, second and third criteria are met. The Department provides overall leadership and keeps abreast of developments through the MHR Working Group and the MHR Steering Committee. There are systems to assign responsibility, allocate resources and track progress on this priority.

The fourth criterion was partially met. The progress by the Department, AMHB and RHAs to establish information requirements and measures clearly advances the priority, but progress is slow. Without working systems, overall progress in mental health service delivery in Alberta is difficult to analyze.

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[5] On the AMHB website: http://www.amhb.ab.ca/Initiatives/statistics/Pages/ReportsandPublications.aspx

Develop more detailed plans for implementing the Mental Health Plan and monitoring progress. While this Plan sets the overall direction, the next step is to develop implementation plans and priorities and to monitor and report on progress in implementing the Plan over time. The Alberta Mental Health Board, in partnership with the regional health authorities, and in collaboration with Alberta Health and Wellness and other key stakeholders, should initiate and facilitate the development of an approach for advancing mental health within the context of the Provincial Mental Health Plan. Within three years, progress on implementing the Plan should be assessed and changes to the Plan should be made as necessary.

Summary

As the priority states, many participants are involved in implementing the *Plan*. For this priority, we expected that a group or entity would ensure that implementations plans were completed for all priorities, plan quality was adequate, and progress monitored against those plans. This did not happen, nor is it clear who would be responsible for this oversight role. The three-year assessment has not taken place. The AMHB expects to complete it in 2008–2009.

Conclusions

The criteria were not met for this priority.

Seniors Care and Programs

1. Summary

Following up on our 2005 report to assess the status of 4 key recommendations

In 2005, we audited systems that the Department of Health and Wellness, the Department of Seniors and Community Supports, (the Departments) and Alberta's nine Regional Health Authorities (RHAs) use to deliver services in long-term care facilities. We also audited systems for establishing and maintaining standards in the Seniors Lodge Program, assisted living and other supportive living settings. Our 2005 *Report of the Auditor General on Seniors Care and Programs* had 13 recommendations. We now report on the Departments' and RHAs' progress implementing the following 4 key recommendations from our 2005 work:

1. updating and implementing standards for service delivery in long-term care facilities,
2. improving systems to monitor compliance with standards,
3. establishing standards for assisted living and other supportive living facilities, and
4. updating Seniors Lodge standards and implementing a process to maintain them.

We will assess the status of the remaining recommendations in future reports[1].

New standards replace Basic Service Standards

The Departments and RHAs have developed and introduced new standards for care and accommodation. The Basic Service Standards for continuing care facilities that we reported on in 2005 have been replaced with three separate sets of standards—continuing care health service standards, long-term care accommodation standards and supportive living accommodation standards.

More spaces created

Hiring nurses still a challenge

Growth in supported living facilities continues to provide a continuum of care for individuals moving from their homes and seniors complexes to facilities offering higher levels of care. More beds have been established in long-term care facilities and more staff hired to care for residents. Attracting and retaining nursing personnel is a challenge, but several domestic and international initiatives are underway.[2]

In this audit, we focused on systems at the Departments and RHAs to implement the new standards and monitor long-term care and supportive-living facilities for compliance with standards. As part of our examination of these systems we visited—with RHA and Department personnel—11 long-term care facilities and 4 supportive-living facilities.

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[1] An overview of management actions for these nine recommendations is in Appendix B

[2] Refer to Alberta Health and Wellness News Release, dated December 10, 2007 at http://alberta.ca/acn/200712

Standards have been updated or established

We conclude that the Departments have implemented our recommendation to implement a system to maintain and update standards. Seven RHAs have systems to develop, maintain and implement the new care standards, and two have made satisfactory progress. Also, standards for care and accommodation in supportive living settings were developed. Staff in long-term care facilities are aware of the standards, and place more emphasis on meeting critical standards such as medication management.

Progress made, but monitoring systems need to improve

The Departments and RHAs have developed systems to monitor compliance with the new standards. Although progress has been made since our 2005 report, further work is required.

Conclusion about monitoring compliance

RHA monitoring at different stages of development

We conclude:

- the Department of Seniors and Community Supports has made satisfactory progress toward developing a system to monitor compliance with the accommodation standards,
- the Department of Health and Wellness has made satisfactory progress but needs to further develop systems pertaining to RHA monitoring activities, receiving and reviewing data, and monitoring facility compliance with care standards,
- Calgary, Capital and Palliser RHAs have developed fully functioning compliance monitoring functions; Aspen, Chinook, David Thompson, East Central and Northern Lights RHAs have made satisfactory progress toward that goal. We have repeated our recommendation to Peace Country RHA[3] because they have made limited progress in developing a compliance monitoring system.

To fully implement the recommendation to improve compliance monitoring, the Departments and RHAs need to complete development of their compliance monitoring programs. They also need to complete inspections of all facilities and enforce compliance through future inspections or follow-up action.

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[3] See Appendix A for results of our RHA work

2. Audit objectives and scope

2.1 Our audit objective

Our objective was to determine if the Departments and RHAs have implemented 4 key recommendations from our 2005 report by:

- implementing the new standards for care and accommodation in long-term care and supportive living facilities, and
- having adequate systems to monitor compliance with the standards.

2.2 Our scope

We examined the:

- roles and responsibilities of the Departments, RHAs and facility operators,
- systems the Departments used to develop, implement and update the standards,
- processes Departments used to monitor RHA and facility compliance with standards, and
- processes the RHAs used to monitor facility compliance with standards.

We also wanted to obtain an update on any progress on the remaining recommendations from our 2005 report. See Appendix B for details.

We conducted our field work from October 2007 to January 2008 and focused on the Departments' and RHAs' actions since our 2005 report. We visited all nine RHAs and the corporate offices of each Department. We conducted extensive interviews with Department and RHA staff, and visited–with RHA and Department personnel—11 long-term care facilities and 4 supportive living facilities.

3. Systems for providing care and accommodation

3.1 Continuing care services

Care services are a broad range of health, social, and personal care services provided by the Government of Alberta to both seniors and dependent adults in the following settings:

Table 1—Continuing care services[4]

Possible Settings				
Single Dwellings/ Apartments	Other Supportive Living Facilities—for example, Seniors Complexes and Group Homes	Lodges/ Enhanced Lodges	Assisted Living/ Designated Assisted Living	Long-Term Care Facilities—Nursing Homes and Auxiliary Hospitals
Home Living	Supportive Living			Facility living

Facility living services are provided under legislation

Facility living settings such as nursing homes and auxiliary hospitals are governed by the *Nursing Homes Act*, the *Hospitals Act* and associated regulations. Facility living differs from supportive living by providing care for residents with serious, chronic or unpredictable conditions who require access to registered nursing services on a 24-hour basis. Nurses can respond to the need for unscheduled assessments and prescribe interventions. Facility living also has specialized physical design and infrastructure to meet highly complex needs.

Supportive living

Supportive living facilities may be operated by publicly funded non-profit organizations, private non-profit organizations or for-profit companies. As explained in the Supportive Living Framework[4] supportive living facilities provide increasing levels of care to individuals across the continuum from seniors' complexes and group homes to lodges, assisted living and designated assisted living facilities. They may provide 24 hour nursing services, however, a registered nurse is not always present.

3.2 The new standards

The Departments developed and introduced new care and accommodation standards to the RHAs and facility operators. Replacing the Basic Service Standards are three separate sets of standards – health service standards, long-term care accommodation standards and supportive living accommodation standards.

The following table summarizes the 3 new standards and the key areas they cover:

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[4] Department of Seniors and Community Supports, Supportive Living Framework—March 2007 (see: http://www.seniors.gov.ab.ca/housing/continuingcare/standards_framework.pdf)

Table 2—Care and accommodation standards

Standards[5]	Responsibility	Applies to	Key areas covered
Continuing Care Health Service Standards	Department of Health and Wellness (Health)	publicly-funded health care services provided in facility based, supportive living and home living settings	• client concerns • promoting wellness • standardized assessment • care plans • medication management • operational processes • health care providers • service coordination • therapeutic services • quality improvement
Long-Term Care Accommodation Standards	Department of Seniors and Community Supports	accommodation services provided in all facility based settings	• physical environment • hospitality services • safety services • personal services[6] • service coordination • residential services • human resources • management and administration
Supportive Living Accommodation Standards	Department of Seniors and Community Supports	accommodation services provided in all supportive living settings	• physical environment • hospitality services • safety services • personal services[6] • service coordination • residential services • human resources • management and administration

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[5] A complete copy of the standards is available at http://www.continuingcare.gov.ab.ca/Documents_news.htm

[6] Personal services are optional services that may be provided or acquired at a resident's own expense to promote independence and well-being.

Outcome-focused standards

The standards are outcome-focused and provide guidance in areas of importance—integrated care plans and quality improvement. Some standards require RHAs to establish policies and processes for health service providers, medication management and to ensure that all facilities have a concerns resolution process.

3.4 Roles and responsibilities

3.4.1. Minister of Health and Wellness

The Minister:

Minister responsible for health issues

- sets the overall direction, priorities and expectations, including standards,
- allocates resources,
- ensures the delivery of quality publicly funded health services, including access and processes to resolve health concerns,
- measures and reports on the performance of the health system to the legislative assembly and the public,
- makes regulations under the *Nursing Homes Act* on basic services to be offered, the level of staffing and operation of nursing homes, and
- may enter and inspect facilities under the *Nursing Homes Act* and take appropriate action if residents are at risk or legislation has been contravened.

3.4.2 Department of Health and Wellness (Health)

Health carries out Minister's responsibilities

Health assists the Minister by:

- monitoring and ensuring RHA compliance with legislation and continuing care standards,
- making recommendations about RHA business plans and budgets, and providing funds, and
- evaluating the performance of the health system.

3.4.3 Minister of Seniors and Community Supports

The Minister:

Minister responsible for accommodation issues

- sets the overall direction, priorities and expectations – including standards,
- allocates resources,
- prepares for the needs of an aging population and facilitates availability of supports to seniors, and
- directs planning to expand supportive living facilities and improve compliance with accommodation standards.

3.4.4 Department of Seniors and Community Supports (SCS)

SCS carries out Minister's responsibilities

SCS assists the Minister by:

- developing and maintaining accommodation standards applicable to both long-term care and adult supportive living environments,
- monitoring individual facilities for compliance with the standards
- encouraging and promoting ongoing quality improvement in accommodation services, and
- working with RHAs to comply with the long-term care accommodation standards in facilities.

3.4.5 RHAs

RHAs provide care and accommodation

Alberta's nine RHAs are accountable to the Minister of Health and Wellness under a regionalized, publicly funded service delivery model, and are responsible for:

- planning and delivering long-term care services and ensuring that home care is available for people who need it,
- adhering to provincial standards in delivering services,
- complying with other federal, provincial and municipal legislation including the *Health Professions Act*, the *Nursing Homes Act*, the *Public Health Act* and the *Hospitals Act*, and
- providing publicly funded health care services in supportive living settings.

3.5 Long-term care facilities

The following table details numbers of continuing care beds in each RHA, with comparative data from 2005:

Beds have increased since 2005 in Calgary and Edmonton

Table 3—Facilities and beds[7]

RHA	Facilities		Beds	
	2005	**2007**	**2005**	**2007**
Chinook—Lethbridge	12	11	806	731
Palliser—Medicine Hat	10	10	552	519
Calgary	42	45	4,504	4,657
David Thompson—Red Deer	25	26	1,405	1,399
East Central—Camrose	17	17	942	878
Capital—Edmonton	34	37	4,452	4,690
Aspen—Westlock	23	19	859	825
Peace Country—Grande Prairie	12	12	481	430
Northern Lights—Ft. McMurray	4	4	64	76
Totals	179	181	14,065	14,205

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[7] Unaudited information supplied by RHAs November 2007

Long-term care bed numbers have not risen as dramatically as supportive living facilities.[8] We have been told this is the result of increased emphasis toward supportive living arrangements.[9]

3.5.1 Services and costs

Health and personal care services are provided at no cost to people who need them. RHAs pay for these services and supplies. However, residents must pay user fees for laundry, clothing, and hair care, as well as a monthly charge for their accommodation.

SCS sets the maximum daily accommodation rate that long-term care facilities can charge residents. The following summarizes the maximum rates from 2002 to present:

Rates increased

Table 4—Daily maximum accommodation rates[10]

Room Type	Starting January 1, 2002	Starting August 1, 2003	Starting October 1, 2007
Standard	$ 28.22	$ 39.62	$ 41.50
Semi-Private	$ 29.93	$ 42.00	$ 44.00
Private	$ 32.60	$ 48.30	$ 50.75

Accommodation rates have increased; however, funding provided to low income residents to cope with these increases has also risen proportionately.

3.5.2 Caregivers

Four groups of caregivers

Four types of caregivers provide health and personal care services in long-term care facilities:

- Registered Nurses (RNs)—regulated by the Alberta Association of Registered Nurses. RNs typically complete a minimum two-year diploma program; many complete a four-year university degree program,
- Registered Psychiatric Nurses (RPNs)—regulated by the Registered Psychiatric Nurses Association of Alberta. RPNs typically complete a minimum two-year diploma program; many complete a four-year university degree program,
- Licensed Practical Nurses (LPNs)—regulated by the College of Licensed Practical Nurses of Alberta. LPNs typically complete a 15-month study program in a college, and

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[8] See tables 5 and 6.

[9] For more information on this emphasis, go to http://www.health.gov.ab.ca/key/lt_stratreport.pdf

[10] Information from the Department of Seniors and Community Supports

- Health Care Aides (HCAs)—an unregulated group of workers trained on the job, typically students and graduates of HCA certification programs at colleges and vocational schools.

Health developed a curriculum to train HCAs

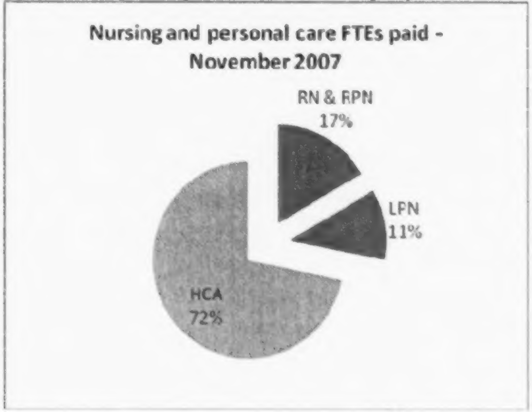
The *Health Professions Act* requires all health professional colleges to follow common rules to investigate complaints and set educational and practice standards for registered members. Health developed a curriculum for HCA training in publicly funded colleges and vocational schools in Alberta. This curriculum is designed to attain a consistency in HCA training and contribute to the overall competency of HCAs. However, HCAs are not required to take the course.

In November 2007, full-time equivalent positions (FTEs) paid in long-term care facilities in Alberta were:[11]

- 1,415 RN and RPN (2005–1,268)
- 986 LPN (2005–944), and
- 6,122 HCA (2005–5,268)

RNs and RPNs are combined due to the relatively low number of RPNs working in long-term care facilities. The relative proportions of caregivers are shown in the following chart:

Chart 1—Nursing and personal care employees[11]



3.6 Supportive living settings

Supportive living meets the needs of a wide range of people, but not those who have highly complex and serious health care needs. These facilities may provide 24-hour nursing services, but a registered nurse is not always present. Unlike residents of long-term care facilities, residents of supportive living facilities are responsible for their own medication and medical supplies.

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[11] Unaudited information supplied by RHAs, November 2007

Various types of supportive living settings

Seniors can access the following types of supportive living settings to meet their housing and care needs:

3.6.1 Assisted living

Residents with more complex needs

There are several assisted living models. Typically, supportive living settings provide residents with nursing care services in addition to housing and personal care services. These facilities often serve residents with more complex needs than other supportive living settings can handle. Designated assisted living facilities are ones where RHAs and owners have a contractual relationship for owners to provide continuing care services in the facilities and where RHAs place people based on their assessed health care needs.

3.6.2 Lodges

Basic room and board for seniors

Lodges provide room and board for seniors who are functionally independent. Core services include basic room with furnishings, meals, housekeeping services, linen services, security, 24 hour non-medical staffing and life enrichment services. Some lodges may provide enhanced services such as personal care, medication assistance and contracted home care services based on the needs of the residents; these facilities are known as Enhanced Lodges. Enhanced Lodges are similar to assisted living facilities but they serve residents with less complex needs than those in assisted living. Medical care for a resident of a lodge may be provided by an RHA through home care services.

3.6.3 Other supportive living settings

Various settings and options

These facilities, such as seniors' complexes and group homes, provide seniors with private living accommodation, a safe environment, 24-hour monitoring and emergency response, meal options, housekeeping, transportation, social and recreational activities and some basic living and personal care services. These facilities are typically operated by non-profit or for-profit organizations.

At March 31, 2004, SCS reported the following spaces available in various settings. Note that the descriptions of spaces have changed since 2004 and the data in tables 5 and 6 is not directly comparable.

Table 5—2005 total seniors supported living and lodge spaces[12]

Type of facility	Number of spaces
Other adult supportive living	12,000
Lodges	8,500
Total	**20,500**

At December 31, 2007, SCS reports an inventory of supportive living facilities with the following spaces:

Table 6—2007 total supportive living facility spaces

Type of facility	Number of spaces
Lodges[13]	9,198
Assisted living	9,042
Designated assisted living	3,038
Other adult supportive living	2,208
Total	**23,486**

At December 31, 2007, the Department of Seniors and Community Supports had inspected and licensed facilities accounting for approximately 14,500 of the spaces identified in Table 6. The inspection program is continuing.

3.7 Monitoring the facilities

Facilities are monitored by several organizations

Several organizations provide oversight, monitor compliance with standards and review other requirements in facility living and supportive living settings.

3.7.1 The Department of Health and Wellness

Health monitors for care standards

Health's compliance monitoring processes is developing and is planned to include testing RHA compliance monitoring processes, inspecting facilities for compliance with care standards and following up on critical incidents.

3.7.2 The Department of Seniors and Community Supports

Seniors inspects for accommodation standards

SCS examines compliance and investigates complaints relating to accommodation standards in both long-term care and supportive living settings, often in conjunction with RHA personnel. SCS visits are typically carried out by one person and typically take one day to complete using a detailed monitoring plan.

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[12] These numbers are approximate, based on unaudited information from SCS

[13] 7,969 of the residents in these spaces receive public funding under the Lodge Assistance Program.

3.7.3 RHAs

RHAs check for compliance with all standards

Each RHA with a compliance monitoring function has a unique inspection process. Visits range from half-day visits by one person, to two day visits by a team of up to seven specialists. Inspections cover both care and accommodation standards, generally involve discussions with several staff, observation of the facility and patient charts and conclude with a discussion of recommendations, if any, including plans to implement them.

3.7.4 Health Facilities Review Committee

Unannounced visits and reports to Minister

The Committee conducts unannounced routine reviews of health care facilities and handles complaint investigations. A complaint investigation cannot by its nature follow a prescribed timeline. Facility visits are carried out by teams of two or more and take several days depending on facility size. These reviews require interviewing staff and residents and may result in recommendations. The Committee reports to the Minister of Health and Wellness.

3.7.5 Health Quality Council of Alberta (HQCA)

Investigations for the Minister or RHA

If requested by the Minister of Health and Wellness or an RHA, the HQCA examines matters and provides advice and recommendations.

3.7.6 RHA public health inspections

Health inspectors check for hygiene

Food preparation services in long-term care facilities are high-risk due to the risk of contamination, and are typically inspected three times a year by RHA personnel. The timing and extent of the review depends on initial findings, but typically covers at least 20 health related criteria.

3.7.7 RHA Infection control inspections

Outbreaks of infections

These inspections, performed by medical personnel, are scheduled quarterly or as outbreaks occur, and are managed in quarantined facilities. They concentrate on best practices to manage outbreaks of infection, such as general cleanliness and hand-washing.

3.7.8 Protection for Persons in Care (PPIC)

Conduct investigations into allegations of abuse

PPIC investigates reports of abuse or safety concerns for adults in publicly funded care facilities. All facilities inform residents and families that PPIC is available if they have any concerns. Facility management and staff are involved in resolving findings from any investigation.

4. Conclusions

We frame our overall conclusions about the Departments' and RHAs' systems to deliver care and accommodation in terms of two basic criteria:

- have the Departments and RHAs implemented the new standards for care and accommodation in long-term care and supportive living facilities?
- do the Departments and RHAs have adequate systems to monitor compliance with standards?

New standards developed and introduced

The Departments and RHAs have systems to develop, introduce, and maintain new care and accommodation standards. However, systems to monitor compliance with those new standards are at various stages of development and further work is required. We conclude that:

- Health and SCS have each successfully developed and introduced new standards for care and accommodation in long-term care and supportive living facilities,
- Health and SCS have achieved satisfactory progress in establishing compliance monitoring functions for these new standards,
- Calgary, Capital and Palliser RHAs have adequately functioning compliance monitoring systems for the new standards,
- Aspen, Chinook, David Thompson, East Central and Northern Lights RHAs have achieved satisfactory progress in establishing compliance monitoring functions for the new standards, and
- Peace Country RHA has achieved limited progress in establishing compliance monitoring functions for the new standards, and we have repeated our recommendation.

Monitoring compliance at different development stages

To provide a structure at the beginning of our work, we developed and agreed with management on four audit criteria, relating to the four 2005 recommendations that our follow-up work is based on. The following table details our assessment:

Assessment of progress on four 2005 recommendations

Table 7—Assessment of follow-up recommendations

2005 Recommendation	Health	SCS	RHAs
5.1 Develop and maintain standards for facility living	Implemented	Implemented	See Appendix A
5.2 Monitor compliance for facility living	Satisfactory progress	Satisfactory progress	See Appendix A
5.3 Establish standards for supportive living	Implemented	Implemented	N/A
5.4 Update standards and improve monitoring for Supportive Living and Seniors Lodge settings	N/A	Implemented	N/A

5. Our audit findings

5.1 Systems to develop and maintain standards

Background

In 2005, we recommended that Health, working with the RHAs and SCS, update the Basic Service Standards for services in long-term care facilities and implement a system to regularly review and update the Basic Service Standards to ensure they remain current.

Our audit findings

Both Departments and seven of nine RHAs fully implemented this recommendation

The Basic Service Standards have been replaced by continuing care health service standards, (developed and administered by Health) long-term care accommodation standards (developed and administered by SCS) and supportive living accommodation standards (also developed and administered by SCS). The Departments, RHAs and stakeholders worked together to develop these three new standards and also to discuss and consult with stakeholders any need for updates. We have assessed that each of the Departments, and Aspen, Calgary, Capital, Chinook, David Thompson, East Central, and Palliser RHAs have implemented this recommendation. Northern Lights and Peace Country RHAs have made satisfactory progress toward implementing this recommendation.

5.1.1 Department of Health and Wellness (Health)—implemented

Developing standards

New care standards introduced and implemented

Health issued the Continuing Care Health Service Standards on May 3, 2006 for implementation by March 31, 2007. In July 2007, the Department finalized a four-phase process to review and update the standards annually for three years and at five year intervals thereafter.

Implementing and communicating standards

Health:

- developed the Continuing Care Desktop, a web-based computerized information tool to help RHAs and facilities in training,
- supported RHAs in training sessions by funding instruction time for all staff, and
- supported RHAs by targeted funding to increase staff time and acquire capital assets.

Maintaining and updating the standards

Feedback from general sources for promised updates

Health consulted with staff, RHAs, operators, professional associations, and special interest groups to obtain feedback on the currency and relevancy of the new care standards. Health participates in the Continuing Care Leaders Council with representatives of all RHAs and SCS. One mandate of this Council is to bring forward suggestions and recommendations for revision and updating of the standards. In the past year, Health has revised implementation target dates for two standards by:

Standards about computer system and health aide training revised

- removing the September 2007 deadline for the implementation of a computerized system for assessing residents and developing and managing care plans, and
- removing the March 2008 deadline for health care aides to have achieved core competencies.

Health told us it is committed to implementing these two care standards, and is working with RHAs to achieve results in appropriate timelines.

Standards will be further updated in April 2008

Health set an April 1, 2008 deadline to release updated care standards. It consulted with RHAs, operators and professional organizations during 2007.

5.1.2 Department of Seniors and Community Supports (SCS)—implemented

Developing standards

New accommodation standards introduced

The Long-Term Care Accommodation Standards and Supportive Living Accommodation Standards cover the physical environment, hospitality services, safety services, personal services, and residential services to residents of long-term care facilities. These standards also cover coordination and referral services, human resources and management and administration of facility operators. Consulting with stakeholders at appropriate times, SCS issued draft accommodation standards in June 2005, revised them in 2006 and finalized them in March 2007.

Implementing and communicating standards

Training completed

The introduction of new accommodation standards included training sessions for facility operators and RHAs in various locations during March and April 2007.

SCS' Accommodation Standards and Licensing Unit contracts with consultants who help facility operators prepare for an accommodation standards compliance inspection. This assistance may include interpretation of the standards, discussion of current practices and development of work plans to help the facility comply. The consultants do not inspect the facilities for compliance; but copies of their notes go to SCS inspectors.

Maintaining and updating standards

Process to update and make changes

The new accommodation standards have been in place since March 2007. In January 2008, SCS initiated a periodic and ongoing process to review them. From January to May 2008, a review team will meet to collect and assess feedback on the existing accommodation standards and propose revisions.

5.1.3 RHAs

RHAs had either successfully implemented or were progressing satisfactorily

We found all RHAs had successfully introduced the new standards and trained facility staff, or were making satisfactory progress in doing so. Northern Lights and Peace Country RHAs had not yet completed some training processes and policy drafting. The following table shows the RHAs' progress:

Table 8—RHA results: developing and maintaining standards[14]

Region	Develop, maintain and implement standards
Chinook—Lethbridge	Implemented
Palliser—Medicine Hat	Implemented
Calgary	Implemented
David Thompson—Red Deer	Implemented
East Central—Vegreville	Implemented
Capital—Edmonton	Implemented
Aspen—Westlock	Implemented
Peace Country—Grande Prairie	Satisfactory progress
Northern Lights—Ft. McMurray	Satisfactory progress

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[14] See Appendix A for more detail on the work we conducted in the RHAs.

5.2 Systems to monitor compliance with standards

Background

In 2005, we recommended that the Departments and RHAs improve the systems for monitoring the compliance of long-term care facilities with the Basic Service Standards. As Section 5.1 explains, the Basic Service Standards were replaced by three new sets of standards.

Our audit findings

Satisfactory progress

Overall, we found that the Departments and RHAs made satisfactory progress toward developing systems to monitor compliance with the care and accommodation standards. To have fully functioning monitoring systems, more work needs to be done at the Department of Health and Wellness than the Department of Seniors and Community Supports. Some RHAs have developed systems to monitor compliance with care standards; other RHAs have taken limited action and told us they were awaiting guidance from Health.

5.2.1 Department of Health and Wellness (Health)—satisfactory progress

Health requires RHAs to comply

Health issued directives in April 2007 requiring RHAs to comply with the Continuing Care Health Service Standards (care standards) for all contracted or publicly funded continuing care services provided in nursing homes, auxiliary hospitals and home care programs.

RHAs responsible for compliance, but some have made limited progress

RHAs are primarily responsible to monitor care standards and are in different stages of establishing compliance monitoring functions. RHAs must report annually to the Minister[15], summarizing their compliance with the care standards and relevant legislation.

RHAs use different methods of gathering and interpreting data

RHAs that have made progress on a standards compliance monitoring function have independently developed audit tools and completed inspections. Therefore, the data arising from these inspections may not be consistent or suitable for trend analysis or cross-RHA comparisons.

Health to monitor RHA programs, track data and conduct audits

Health established a compliance monitoring unit in April 2007 to:

- monitor annual RHA reporting of compliance with the care standards,
- track, monitor and follow-up on reportable critical incidents,
- conduct high-risk field audits in RHAs resulting from critical incidents or other significant risks identified in the region, and
- conduct audits at RHAs to validate what is reported.

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[15] Continuing Care Health Service Standard # 23

Developing monitoring program

To December 31, 2007, the compliance monitoring unit had:

- worked with RHAs to develop a common definition of a critical incident for reporting purposes. This is ongoing and waiting for RHA input. No tracking or trending of data is anticipated until that process has been completed.
- developed a draft audit plan for facility visits, which was not shared with RHAs. RHAs created their own audit plans, and have not shared them with the compliance monitoring unit,
- visited Peace Country RHA and audited three long-term care facilities, a designated assisted living facility and the RHA home care program. The compliance monitoring unit shared results with the RHA and the facility and then made a follow-up visit to reassess deficiencies found in the original audit,
- tentatively planned visits to other RHAs for early 2008,
- hired a new director and an additional nurse consultant to further develop its compliance function,
- engaged a consulting firm to help in the compliance function,
- drafted requirements for RHA reporting of compliance with the care standards, audit activities and compliance monitoring plans, and
- continued to recruit additional staff to carry out planned annual visits to each RHA.

Some visits completed and more planned

New staff hired

Recruiting is ongoing

RHAs have not reported their compliance to Health

For the year ended March 31, 2007, no RHAs had complied with the care standard to report annually in writing to the Minister on their compliance with the care standards and legislation. Also, Health had not yet implemented a policy or procedure setting out the form of reporting or the consequences of non-compliance.

Facilities are subject of many inspections, visits and reviews

Facility operators face a number of monitoring processes in their regular business; each process consumes operator time and resources and may result in recommendations and subsequent follow-up visits. Facility operators told us the quantity of inspections and associated work is intense and time consuming. They view inspections as necessary, but want a more coordinated monitoring process to minimize resources needed and perceived duplication of audit processes.

To fully implement its systems to monitor RHA compliance with the care standards, Health needs to:

Health needs to complete development of the monitoring function

- finalize the template for RHAs to submit summaries of their compliance with the standards, and establish a policy and follow-up process if RHAs do not report,
- develop a risk-based selection processes for audits, finalize a work-plan for field audits, and conduct audits and follow-up on deficiencies identified,
- define what constitutes a critical incident reportable to Health and establish a process to follow-up on these incidents,
- track and monitor information from critical incident reporting and field audits to identify risks to continuing care residents,
- validate the compliance monitoring process results at RHAs, using independent risk-based testing and working with RHAs to ensure data is comparable and consistent.
- share tools and data with RHAs to apply consistency to monitoring processes,
- assess the various facility inspection processes underway by considering potentially overlapping responsibilities and potential efficiencies.

5.2.2 Department of Seniors and Community Supports (SCS)—satisfactory progress

SCS has a functioning compliance initiative

SCS developed and implemented processes for monitoring the compliance of long-term care facilities with the Long-Term Care Accommodation Standards. SCS conducts:

- inspections in conjunction with RHAs to examine facility compliance with accommodation standards; and
- investigations of specific complaints received from facility residents, families, members of the public, and others.

SCS established an Accommodation Standards and Licensing Unit to monitor compliance with accommodation standards. SCS has worked with RHAs and Health to confirm the inventory of long-term care facilities in the province and to establish protocols for conducting and reporting the results of inspections. The protocols were still being finalized in January 2008.

Joint inspections with RHAs

SCS and the RHAs have agreed, when possible, to conduct joint facility inspections. They expect this to increase efficiency of the inspection process and minimize the disruption to facility operations that could result from multiple inspection visits. Facility inspections began in long-term care facilities in December 2007.

SCS uses a standardized checklist to document the inspection process. If non-compliance is noted, the inspector prepares a summary report and action plan and leaves it with the facility operator. A follow-up inspection is then scheduled to assess the facility's progress in complying with the standards.

Results of inspections

Lack of documentation to support compliance

SCS inspected two facilities in the Capital RHA and five facilities in the David Thompson RHA in December 2007. None of the facilities complied with all accommodation standards. Facilities generally lacked documentation to demonstrate compliance with standards.

Areas of non-compliance found by SCS inspectors

Major areas of non-compliance were:
- hygiene, including safe food handling and facility cleanliness,
- emergency preparedness and security, and
- facility maintenance.

Follow-up not yet completed

Follow-up inspections of these facilities were not complete when we finished our examination. We could not assess SCS' follow up processes or facilities' progress in resolving the non-compliance.

Complaint and incidents

Complaints investigated

The Accommodation Standards and Compliance Unit investigates complaints related to accommodation standards. The Unit records information on specific complaints, including the nature of the complaint, facility, and complainant. Then it assesses each complaint for priority and jurisdiction. The Unit sends complaints that fall outside of SCS jurisdiction to the appropriate agency for investigation. Complaints that fall within SCS jurisdiction are assigned to an investigator.

Results shared with complainant and facility

SCS reports investigation results to both the facility operator and the complainant. For substantiated complaints, SCS develops an action plan to solve the problem. The investigation may result in recommendations to facility operators. An inspector will later assess if the recommendations have been implemented.

Reporting

SCS plans to publish website reports in a year

SCS is developing web-based reporting of compliance with the accommodation standards on a facility by facility basis. It plans to report this information publicly within the next 12 months.

SCS needs to show compliance rates are improving

To fully implement this recommendation, SCS needs to complete its inspections in all long-term care facilities and, where facilities did not meet all standards in the initial inspection, ensure compliance with the standards through re-inspection.

5.2.3 RHAs

RHA monitoring processes are inconsistent

Systems for monitoring compliance with care standards vary widely. Calgary, Capital and Palliser RHAs had functioning compliance monitoring systems–they each used different tools and processes to assess compliance. Aspen, Chinook, David Thompson, East Central and Northern Lights RHAs are establishing monitoring functions. Peace Country RHA has made limited progress.

Data is not comparable across RHAs because systems are different

With only limited data gathered using a variety of processes and tools, we can't compare compliance rates across RHAs or assess provincial rates. However, standards covering critical areas, such as medication management, are receiving considerable attention across all RHAs, including those without functioning compliance monitoring systems.

The following table shows the RHAs' progress:[16]

Table 9—RHAs: systems to monitor compliance with care standards

RHA	Monitor compliance
Chinook—Lethbridge	Satisfactory progress
Palliser—Medicine Hat	Implemented
Calgary	Implemented
David Thompson—Red Deer	Satisfactory progress
East Central—Vegreville	Satisfactory progress
Capital—Edmonton	Implemented
Aspen—Westlock	Satisfactory progress
Peace Country—Grande Prairie	Recommendation repeated
Northern Lights—Ft. McMurray	Satisfactory progress

To fully implement the recommendation, RHAs need to show that they have finished implementing their processes to monitor compliance with the care and accommodation standards for services provided in their RHA. A fully functioning monitoring system should identify and resolve non-compliance issues appropriately and promptly.

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[16] See Appendix A for detailed results of our RHA work. RHAs that have implemented this recommendation (Palliser, Calgary and Capital) represent about 70% of long term care facility beds. RHAs demonstrating satisfactory progress (Chinook, David Thompson, East Central, Northern Lights and Aspen) represent approximately 27% of long term care facility beds and the remaining RHA (Peace Country) represents about 3% of long term care facility beds.

5.3 Standards for assisted living and other supportive living settings

Background

In 2005, we recommended that the Departments establish standards for care and housing services provided in assisted living and other supportive living settings.

Our audit findings

5.3.1 Department of Health and Wellness—implemented

Care standards apply to assisted and supportive living

The Continuing Care Health Service Standards apply to all publicly funded continuing care health services in long-term care facilities and supportive living settings.

5.3.2 Department of Seniors and Community Supports—implemented

SCS developed accommodation standards

SCS has developed a set of Supportive Living Accommodation Standards with input from stakeholders, and in conjunction with the long-term care accommodation standards. These standards apply to a range of supportive living facilities including Seniors Lodges, Designated Assisted Living facilities and group homes. The key activities and dates for the implementation of these standards are described in section 5.1.2 of this report.

SCS Accommodation Standards and Licensing Unit began inspecting and licensing facilities on April 2, 2007. By December 31, 2007, it had done 505 inspections at 319 separate facilities as follows:

Inspections of 319 facilities

Table 10—Inspections

Type of inspection	Number of inspections
Other adult supportive living facilities	341
Assisting living facilities	145
Designated assisted living facilities	19
Total	**505**

If a facility does not meet all accommodation standards, the inspector prepares a *Monitoring and Site Visit Summary* itemizing areas of non-compliance. The facility operator must remedy the non-compliance. A conditional license will be issued to the facility, and a subsequent re-inspection will assess the facility operator's progress in solving the problem. When all standards are met, a full license will be issued.

The results of inspections and re-inspections to December 31, 2007 follow:

Results of inspections

Table 11—Supportive living accommodation standards inspections

Results	Number of facilities
Met all standards on initial inspection	179
Met all standards after subsequent inspection	95
Awaiting subsequent inspections	32
Not meeting some standards after multiple inspections[17]	13
Total	**319**

Overall, 274 facilities (86%) inspected now comply with the Supportive Living Accommodation Standards. The remaining 45 facilities are working toward compliance.

5.4 Standards and monitoring—Seniors lodge program

Background

In 2005, we recommended that the Department of Seniors and Community Supports:

- update the seniors lodge standards and implement a process to maintain them.
- improve its systems to monitor management bodies' compliance with the seniors lodge standards.

Our audit findings

Updating standards—implemented

Standards developed for Seniors' Lodges

SCS developed supportive living accommodation standards in conjunction with the long-term care accommodation standards. These standards apply to a range of supportive living facilities including Seniors' Lodges, Designated Assisted Living facilities and group homes.

Monitoring compliance—implemented

Monitoring is taking place

Monitoring of seniors lodges takes place under the *Alberta Housing Act*. Seniors' lodges are not licensed by SCS because lodges are not subject to the *Social Care Facilities Licensing Act*. SCS has drafted a proposed *Supportive Living Accommodation Licensing Act* to establish a licensing mandate for all adult supportive living facilities. The legislation has not been tabled in the Legislature.

Majority of lodges inspected before new standards

SCS inspected all seniors' lodges for compliance with the accommodation standards in effect between 2005 and 2007. The majority of these inspections were performed before the approval of the new standards. When facilities didn't comply on the initial inspection, their administering management bodies had to prepare and submit plans to solve the non-compliance problems. SCS followed up on management bodies' progress in implementing their plans.

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[17] Typically operating under conditional license while achieving compliance.

The inspections, and subsequent follow-up activities, result in the following levels of compliance with the standards used for the inspection:

Table 12—Inspections in lodges

Action	2007	2006	2005	Total
Inspections conducted	75	35	31	141
Facilities compliant with all standards	42	25	31	98
Action plans received, not yet compliant with some standards	25	10	-	35
Action plans not yet received	8	-	-	8

Responsibility for ongoing Seniors' Lodge inspections will be assigned to the Accommodation Standards and Licensing Unit in April 2008. Future inspections will use the same standards and criteria as other supportive living facilities. Lodges cannot be licensed until the proposed *Supportive Living Accommodation Licensing Act* is proclaimed.

Appendix A—RHA visits

We visited all 9 RHAs to follow-up on their progress towards implementing our 2005 recommendations. Our visits focused on recommendations concerning the establishment and monitoring of the new care and accommodation standards. Our audit procedure consisted of:

- document collection and review,
- interviews with senior management, and
- facility visits and discussions with staff.

We completed our fieldwork in December 2007.

Each RHA faces unique challenges implementing our recommendations and approached implementation differently, resulting in 9 systems being developed. Every RHA is at a different phase of system implementation, ranging from well established to just beginning.

We did not inspect facilities for compliance; instead, we audited the RHA processes to inspect facilities. We did this through observation and document review. Every RHA has a unique system. They range from a formal audit carried out by several people over two days to a review of a facility self audit. This variation reflects not only regional philosophies but their capacity to develop effective monitoring systems.

Reports specific to each RHA follow:

Region	**Page #**
Chinook—Lethbridge	121
Palliser—Medicine Hat	123
Calgary	125
David Thompson—Red Deer	127
East Central—Vegreville	129
Capital—Edmonton	131
Aspen—Westlock	134
Peace Country—Grande Prairie	137
Northern Lights—Ft. McMurray	140

Summary of audit results for Chinook Health Region

1. Systems to develop and maintain current standards—implemented

We recommended that the Department of Health and Wellness, working with the Regional Health Authorities and the Department of Seniors and Community Supports, update the Basic Service Standards for services in long-term care facilities and implement a system to regularly review and update the Basic Service Standards to ensure they remain current.

Standards for services

The Region has introduced the standards by:

- establishing Chinook Continuing Care Council (4Cs) to implement the new standards,
- performing a gap analysis to identify improvements to policy,
- ensuring facility specific policies or procedures comply with standards, and
- participating regularly in provincial working groups and working with other RHAs and the Departments to interpret and implement the standards.

Changes to standards

The Region has participated in processes for providing input and suggestions for changes to standards by:

- soliciting feedback on standards from facility operators, and providing feedback to the Department when they believe there should be a change in the standards, and
- examining monitoring results, complaints and incidents to determine the need for changes to standards, policies or procedures.

Communication of standards

The Region has communicated the new standards by:

- participating in the Continuing Care Desktop (Desktop) pilot project, and
- developing a toolkit for health care aides to help with the education related to the new standards.

2. Systems to ensure compliance with standards—satisfactory progress

We recommended that the Department of Health and Wellness and the Regional Health Authorities, working with the Department of Seniors and Community Supports, improve the systems for monitoring the compliance of long-term care facilities with the Basic Service Standards.

Compliance with standards

The Region:

- monitors results from the assessment tool, if an outcome is out of the acceptable range, discussions with the facility ensue,
- requires each facility to complete an annual self assessment for review by Chinook staff, facility specific reports, such as incident and PPIC may be included in this review, and
- implemented an electronic information management system that provides measures of quality indicators and information on developing trends within the Region.

Complaints and incidents

The Region:

- established a policy on dealing with complaints and incidents, and
- provided a concise definition of critical incidents and reporting requirements to facilities.

Facility inspection and corrective action

The Region has implemented an electronic information management system that provides measures of quality indicators and information on developing trends within the Region. There is no independent review process to assess compliance with standards.

To finish implementing the recommendation, the Region needs to develop systems to:

- inspect facilities for compliance with standards and establish processes to resolve non-compliance.

Summary of audit results for Palliser Health Region

1. Systems to develop and maintain current standards—implemented

We recommended that the Department of Health and Wellness, working with the Regional Health Authorities and the Department of Seniors and Community Supports, update the Basic Service Standards for services in long-term care facilities and implement a system to regularly review and update the Basic Service Standards to ensure they remain current.

Standards for services

The Region introduced the standards by:

- participating regularly in provincial working groups and working with other RHAs and the Department to interpret and implement the standards,
- creating a regional continuing care network and owner/operator committees,
- creating a continuing care standards team to oversee implementation of the standards, and
- developing a Board approved statement of purpose and objective in collaboration with facility operators.

Changes to standards

The Region has participated in processes for providing input and suggestions for standard changes by:

- examining monitoring results, complaints and incidents to determine the need for changes to standards, policies or procedures. To date, no standards have been changed as a result of this evaluation.

Communication of standards

The Region has communicated the new standards to facilities and staff by:

- hiring a regional educator responsible to provide training on the new standards,
- providing Continuing Care Desktop training to facilities,
- developing an education strategy targeted at health care aides, and
- developing educational materials and training programs for staff with on-site and video conference delivery.

2. Systems to ensure compliance with standards—implemented

We recommended that the Department of Health and Wellness and the Regional Health Authorities, working with the Department of Seniors and Community Supports, improve the systems for monitoring the compliance of long-term care facilities with the Basic Service Standards.

Compliance with standards

The Region:

- developed a standardized review process to monitor and enforce compliance with the new standards.
- requires annual written confirmation from each long-term care facility that they will operate in compliance with applicable acts, standards, policies and procedures.
- developed clinical quality indicators for quarterly reporting by facilities.

Complaints and incidents

The Region:

- established a policy on dealing with complaints and incidents, and
- provided a definition of critical incidents and reporting requirements to facilities.

Facility inspections and corrective action

The Region has developed a process to conduct regular facility inspections. In 2006–2007, the Region completed inspections of 17 long-term care and designated assisted living facilities, using an audit tool modeled on the Continuing Care Health Service Standards. We saw evidence that appropriate follow-ups were done when compliance issues were identified.

Summary of audit results for Calgary Health Region

1. Systems to develop and maintain current standards—implemented

We recommended that the Department of Health and Wellness, working with the Regional Health Authorities and the Department of Seniors and Community Supports, update the Basic Service Standards for services in long-term care facilities and implement a system to regularly review and update the Basic Service Standards to ensure they remain current.

Standards for services

The Region has introduced the standards by:

- performing a gap analysis to identify improvements to policy,
- ensuring facility specific policies or procedures comply with standards, and
- participating regularly in provincial working groups and working with other RHAs and the Department to interpret and implement the standards.

Changes to standards

The Region has participated in processes for providing input and suggestions for changes to standards by:

- soliciting feedback on standards from facility operators, and providing feedback to the Departments when they believe there should be a change in the standards, and
- examining monitoring results, complaints and incidents to determine the need for changes to standards, policies or procedures.

Communication of standards

The Region has communicated the new standards by:

- participating in the Continuing Care Desktop pilot project,
- developing educational materials for training staff on the new health service standards as well as a monthly update on the implementation of the standards for continuing care providers.

2. Systems to ensure compliance with standards—implemented

We recommended that the Department of Health and Wellness and the Regional Health Authorities, working with the Department of Seniors and Community Supports, improve the systems for monitoring the compliance of long-term care facilities with the Basic Service Standards.

Compliance with standards

The Region:

- developed a standardized review process (Annual Performance Profile) to monitor and enforce compliance with the new standards, and
- requires annual declaration by each long-term care facility that they will operate in compliance with applicable acts, standards, policies and procedures.

Complaints and incidents

The Region:

- established a policy on dealing with complaints and incidents,
- provided a definition of critical incidents and reporting requirements to facilities, and
- assigned specific individuals to address issues arising from critical incidents.

Facility inspections and corrective action

The Region has developed a process to conduct regular facility inspections. In 2007, the Region completed inspections at 37 long-term care facilities as well as one-on-one follow up meetings with all but two contracted service providers. The inspection process is modelled on the Continuing Care Health Service Standards.

Summary of audit results for David Thompson Health Region

1. Systems to develop and maintain current standards—implemented

We recommended that the Department of Health and Wellness, working with the Regional Health Authorities and the Department of Seniors and Community Supports, update the Basic Service Standards for services in long-term care facilities and implement a system to regularly review and update the Basic Service Standards to ensure they remain current.

Standards for services

The Region has introduced the standards by:

- performing a gap analysis to identify improvements to policy,
- ensuring facility specific policies or procedures comply with standards,
- participating regularly in provincial working groups and working with other RHAs and the Department to interpret and implement the standards,
- assigned the clinical operations leader and continuing care clinical nursing practice committee to draft procedures, policies, and a standards implementation plan, and
- supporting a continuing care quality improvement group that meets regularly.

Changes to standards

The Region has participated in providing input and suggestions for standard changes by:

- examining monitoring results, complaints and incidents to determine the need for changes to standards, policies or procedures.

Communication of standards

The Region has communicated the new standards to facilities by:

- participating in the Continuing Care Desktop pilot project,
- surveying and testing staff to ensure communications and training on standards has been effective, and
- holding regular meetings with continuing care managers, staff and facility operators to discuss issues related to standards.

2. Systems to ensure compliance with standards—satisfactory progress

We recommended that the Department of Health and Wellness and the Regional Health Authorities, working with the Department of Seniors and Community Supports, improve the systems for monitoring the compliance of long-term care facilities with the Basic Service Standards.

Compliance with standards
The Region requires written confirmation from long-term care facility operators that they comply with applicable legislation, standards, policies and procedures through the annual signing of the Continuing Care Programs and Services Agreement. An updated version of this agreement is currently being developed.

Complaints and incidents
The Region has established policies and procedures dealing with complaints and incidents. A definition of reportable events has been provided to facilities.

Facility inspections and corrective action
The Region has developed a process to conduct regular facility inspections. Inspections have recently begun, and the Region intends to have completed reviews of all facilities by March 2008. The review process is modeled on the Continuing Care Health Service Standards.

To finish implementing the recommendation, the Region needs to:
Review findings of inspections with facility operators and:

- develop action plans and follow-up requirements to address outstanding issues,
- develop a formal reporting protocol to facility management, Region management and the Region Board of Directors.

Summary of audit results for East Central Health (ECH)

1. Systems to develop and maintain current standards—implemented

We recommended that the Department of Health and Wellness, working with the Regional Health Authorities and the Department of Seniors and Community Supports, update the Basic Service Standards for services in long-term care facilities and implement a system to regularly review and update the Basic Service Standards to ensure they remain current.

Standards for services

The Region has introduced the standards by:

- drafting policies to comply the new standards,
- ensuring that facilities that develop their own policies or procedures do so in compliance with the standards,
- participating regularly in provincial working groups to interpret and implement the standards, and
- working with other Authorities and the Department of Health and Wellness (Department) to develop an interpretation guide for the standards. The guide includes an interpretation and expectations for meeting each standard.

Changes to standards

The Region has participated in processes for providing input and suggestions for changes to standards by:

- soliciting feedback on the standards from their facility operators, and providing feedback to the Department when they believe there should be a change in the standards. For example, facility operators expressed concern about the deadline for health care aides to achieve core competencies. ECH and other Authorities forwarded these concerns to the Department and
- examining complaints and incidents to determine if there should be changes to the standards or if a policy is needed to clarify a standard.

Communication of standards

The Region has communicated the new standards by:

- implementing the Continuing Care Desktop, a software product designed to increase users' understanding of the standards.
- offering training sessions and training materials to facilities and staff on the new standards, and
- meeting frequently with region facility operators as part of the Continuing Care Leadership Team. This team discusses the implementation of the standards and shares best practices.

2. Systems to ensure compliance with standards—satisfactory progress

We recommended that the Department of Health and Wellness and the Regional Health Authorities, working with the Department of Seniors and Community Supports, improve the systems for monitoring the compliance of long-term care facilities with the Basic Service Standards.

Compliance with standards

The Region expects all facilities to comply with the standards. The Region is working with the Department of Health and Wellness to set this expectation in agreements with facilities.

Complaints and incidents

The Region has:

- established a complaint resolution process and provided guidance to facilities on how to deal with complaints and incidents, and
- implemented an electronic Safety Occurrence Reporting System in all facilities to track, identify trends, and report incidents to ECH and/or its associate partner management teams, depending on the level of severity of the incident.

Facility inspections and corrective action

The Region is establishing a process to inspect facilities by:

- distributing a self-audit checklist to all facility operators in the Region. The checklist includes all standards, and requires a self-assessment of whether the standard has been met, not met, or partially met, and a list of evidence that would be required to support compliance with the standard. All facilities completed this self-audit. The Continuing Care Leadership Team, comprised of all facility operators will review the results and identify the top five issues from each facility. A regional action plan will be developed to address any regional trends identified,
- having facility operators conduct peer reviews throughout the Region in 2008–2009. The Region will follow up on non-compliance issues identified,
- overseeing the implementation of an electronic information system in all facilities. This will help the Region in collecting quality of care information.

To finish implementing the recommendation, the Region needs to:

- include expectations for compliance to standards in agreements with facilities,
- inspect facilities for compliance with standards,
- establish processes to resolve non-compliance, and
- analyze the results of self-audits and facility peer audits for trends.

Summary of audit results for Capital Health

1. Systems to develop and maintain current standards—implemented

We recommended that the Department of Health and Wellness, working with the Regional Health Authorities and the Department of Seniors and Community Supports, update the Basic Service Standards for services in long-term care facilities and implement a system to regularly review and update the Basic Service Standards to ensure they remain current.

Standards for services

The Region has introduced the new standards by:

- communicating the new standards to all facility operators through its committee structure, including best practices committee, quality committee and owners and operators committee,
- performing a regional gap analysis for each standard to identify strengths and areas for improvement,
- developing an action plan for areas requiring improvement by reviewing and updating directives, policies and procedures to meet the new standards,
- ensuring that facilities that develop their own policies or procedures do so in compliance with the standards,
- participating regularly in provincial working groups to interpret and implement the standards, and
- working with other Authorities and the Department of Health & Wellness (Department) to develop a standards interpretation guide. The guide includes an interpretation and expectations for meeting each standard. Capital has shared a draft of this interpretation guide with all facility operators.

Changes to standards

The Region has participated in providing input and suggestions for standard changes by:

- soliciting feedback on standards from facility operators, and providing feedback to the Department when they believe there should be a change in the standards. For example, facility operators expressed concern about the deadline for health care aides to achieve core competencies. Capital and other Authorities forwarded these concerns to the Department, and
- examining monitoring results, complaints and incidents to determine the need for changes to standards, policies or procedures. For example, Capital noticed that there were variations in practice in the treatment of urinary tract infections. Working with facility operators, Capital developed an algorithm to help in the implementation of evidence based care for the assessment and treatment of urinary tract infections.

Communication of standards

The Region has communicated the standards by:

- meeting with facility operators,
- providing training sessions and materials to facilities and staff,
- distributing information bulletins,
- participating in the Continuing Care Desktop pilot project in conjunction with the Department. The Desktop is a software product that runs over the Internet and is used to increase users' knowledge about the standards. It includes information on the standards, best practices and links to a number of information and education resources, and
- developing "The Continuing Care Health Services Standards Workbook for Health Care Aides", to help to educate health care aides on the new standards. We reviewed the workbook and concluded that it includes information on all of the relevant standards.

2. Systems to ensure compliance with standards—implemented

We recommended that the Department of Health and Wellness and the Regional Health Authorities, working with the Department of Seniors and Community Supports, improve the systems for monitoring the compliance of long-term care facilities with the Basic Service Standards.

Compliance with standards

The Region sets out expectations in agreements and the service expectation letters that facilities will comply with the standards. Current contracts with long-term care facility operators require compliance with all legislation, policies and provincial and regional standards. Updated contracts with all service providers with more detail on the new standards will be in place by March 2008.

Complaints and incidents

The Region provides guidance to facilities on dealing with complaints and incidents, and has established a complaint resolution process. A concise definition of critical incidents and reporting requirements has been provided to facilities.

Facility inspections and corrective action

The Region has established a process to conduct regular facility inspections, and a risk-based approach to conduct in-depth focused reviews when necessary. We visited a facility with Capital staff and confirmed that reviews cover all standards. In their facility inspection program, Capital:

- partners with the Department of Seniors and Community Supports and Environmental Health to conduct facility reviews. Since the standards were released, Capital has conducted 17 facility reviews, and 55 supportive living reviews. All facilities are intended to be visited every two years, but this may vary due to their risk-based approach,

- conducts two-day reviews using the standards as criteria. The review team consists of a quality consultant, a professional practice leader, a pharmacist, an infection control practitioner, an environmental health inspector and a physician,
- verbally debriefs review findings with the facility operator, and prepares a report of findings and recommendations.
- requires action plans from each facility reviewed that should address any deficiencies identified. If any deficiencies are identified related to priority standards, they are followed up immediately. Timelines for non-priority matters vary due to the seriousness of the matter to be addressed.
- uses the Balanced Scorecard for monitoring trends and reporting internally and to the Board, and collects quarterly information from all facilities and monitors trends on resident falls, pressure ulcers, tuberculosis screening rates, staff and resident influenza immunization rates, resident pneumococcal vaccine rates, complaints received, drug cost per resident day, and number of outbreaks,
- analyzes data, calculates regional averages and sets targets for facilities. Reports for each facility compare the facility to average and to the overall Capital target. Best practices are shared and facilities are supported to make necessary improvements.
- completes focused reviews of facility if necessary, considering the results of data analysis, complaints, outbreaks, and critical incidents. Three in-depth focused reviews have been completed since April 1, 2007, and
- completed implementation of an electronic information system for all facilities in June 2007. This is an additional tool to identify issues in a facility that should be followed up.
- uses the Balanced Scorecard for monitoring trends and reporting to management and the Board. Trends and complaints are monitored and reported by facility. If trends are identified, Capital takes the information to the Region's Quality Council. The Council then establishes the topic as an objective for its work. Quality improvement initiatives are then developed and implemented.

Summary of audit results for Aspen Regional Health

1. Systems to develop and maintain current standards—satisfactory progress

We recommended that the Department of Health and Wellness, working with the Regional Health Authorities and the Department of Seniors and Community Supports, update the Basic Service Standards for services in long-term care facilities and implement a system to regularly review and update the Basic Service Standards to ensure they remain current.

Standards for services

The Region has introduced the new care and accommodation standards by:

- drafting many, but not all policies to comply with the new standards, and
- participating regularly in provincial working groups and working with other RHAs and the Department to interpret and implement the standards.

Changes to standards

The Region has participated in providing input and suggestions for updating standards by:

- meeting regularly and soliciting stakeholder feedback,
- examining complaints and incidents to determine the need for changes to the standards, and
- paying the full tuition cost of upgrading skills for health care aides to address changes in standards.

Communication of standards

The Region has communicated the new standards by:

- participating in the Continuing Care Desktop pilot project,
- conducting training and information sessions, and
- developing new service provider contracts for implementation in April 2008.

To fully implement the recommendation the Region still needs to:

- ensure policies exist for all standards, and
- complete testing and rollout of the Continuing Care Desktop tool to facilitate delivery of information to front-time staff.

2. Systems to ensure compliance with standards—satisfactory progress

We recommended that the Department of Health and Wellness and the Regional Health Authorities, working with the Department of Seniors and Community Supports, improve the systems for monitoring the compliance of long-term care facilities with the Basic Service Standards.

Compliance with standards

The Region expects all facilities to comply with the standards, and is developing a new contract with service providers, scheduled to come into effect April 2008. The draft requires providers to operate in accordance with regional policies that incorporate the standards. There is no such requirement in current contracts.

Complaints and incidents

The Region deals with complaints and incidents by:

- employing a patient concerns officer to investigate complaints made to the Region,
- requiring complaints from residents or their families to be dealt with at the lowest possible level, for instance at the facility level for minor issues. There is no direction or policy to guide facilities on the types of complaints that should be elevated to the Region's management, if only for information purposes, and
- using an electronic incident reporting system that is available to the Region's owned facilities but not privately owned facilities. This system categorizes incidents on the basis of severity, and then automatically distributes incident reports to appropriate management levels, depending on the severity. At this time, the system does not generate reports that would enable trend analysis to be done.

Facility inspections and corrective action

All facilities in the region were visited by an independent third party in January and February 2007. The visits were based on the new continuing care standards. In the visit of 18 long term care centres, the reviewer found 100% compliance to best practice standards and 94% compliance to mandatory health standards. The reviewer also identified use of an electronic management information system resulting in better medication administration for 4 of the 18 centres. We visited a facility in the region with the reviewer during the second annual series of visits and observed that:

- the reviewer uses an audit tool which addresses all standards applicable to facilities. Results are reported to facility management and the Region,

- facility audits and visits are carried out by several groups. In the past year, the Region's contracted facility reviewer, the Department of Seniors and Community Supports, the Health Facilities Review Committee, the Health Quality Council, Protection of Persons in Care and our Office have visited various facilities.
- the Region does some monitoring for trends relating to high-risk standards such as medication and restraints. However, the results of audits, visits and other forms of reporting are acted upon in an ad-hoc manner and there is no coordinated region-wide analysis of this information. We understand that the Region is updating the electronic incident reporting system, with a goal to trend and coordinate region-wide analysis.

To finish implementing the recommendation, the Region needs to:

- implement contracts with service providers that require compliance with standards, and ensure the terms and conditions of the contracts are monitored,
- establish a comprehensive and ongoing compliance monitoring process,
- regularly obtain analyze region wide instances including data from private facilities,
- establish guidelines for facilities to report complaints to appropriate levels, and
- monitor trends in the number and nature of complaints and incidents.

Summary of audit results for Peace Country Health

1. Systems to develop and maintain current standards—satisfactory progress

We recommended that the Department of Health and Wellness, working with the Regional Health Authorities and the Department of Seniors and Community Supports, update the Basic Service Standards for services in long-term care facilities and implement a system to regularly review and update the Basic Service Standards to ensure they remain current.

Standards for services

The Region has introduced the new care and accommodation standards and is:

- beginning to draft policies to comply with the new standards, and
- participating regularly in regional working groups to interpret and implement the standards.

Changes to standards

The Region has participated in providing input and suggestions for standard changes by:

- soliciting feedback on standards from facility operators at Continuing Care Managers meetings, and
- providing feedback to the Department of Health and Wellness (Department) at the Continuing Care Leaders Council when they believe there should be a change in the standards.

Communication of standards

The Region has communicated the new standards by:

- implementing the Continuing Care Desktop in most, but not all facilities. The Desktop is a software product that runs over the Internet and is intended to increase users' knowledge about the standards. It includes information on the standards, evidence, and best practices related to the standards, and links to a number of relevant information and education resources.
- offering training sessions and training materials to facilities and staff on the new standards, and
- meeting frequently with the Region facility operators at the Regional Continuous Quality Improvement Committee, to discuss the implementation of the standards and any suggested changes.

To finish implementing the recommendation the Region needs to:

- examine complaints and incidents to determine if there should be changes to the standards or if a policy is needed to clarify a standard,
- consider the results of the monitoring activities to assess whether it should recommend changes to the standards,
- consider providing its policies and procedures to contracted facility operators,
- complete implementation of the Continuing Care Desktop, and
- develop and communicate policies for all new standards.

2. Systems to ensure compliance with standards—recommendation repeated

We recommended that the Department of Health and Wellness and the Regional Health Authorities, working with the Department of Seniors and Community Supports, improve the systems for monitoring the compliance of long-term care facilities with the Basic Service Standards.

Compliance with standards

The Region is establishing a process to inspect facilities by:

- participating in the Department's pilot project on compliance monitoring. The Department completed compliance follow-up visits in 2007,
- visiting facilities quarterly to discuss and review complaints, incidents, wound care, staffing, and status on standards implementation. However, results of these visits are not documented and do not necessarily ensure compliance with the standards,
- planning to distribute a self assessment tool to all facility operators in the Region. Currently, there is no formal process to deal with the results of these self assessments, and
- planning for regional staff to conduct comprehensive reviews of compliance in all facilities in 2008.

One of the privately operated facilities in the Region has a contract from 1996 which has no requirement to comply with the new standards. During our original visit in 2005, we recommended that the Region update its contract with the operator. As of 2007, the 1996 contract is still in place. The Region is drafting a new contract but has not yet finalized it.

Complaints and incidents

The Region has developed systems to:

- provide guidance to all regionally managed facilities on dealing with complaints,
- document and track complaints for use by regionally operated facilities. Facilities are entering information into the complaint tracking system, however, the information is not being used to monitor trends, and

- document critical incidents through use of a standardized multi–copy form, which is retained in the facility. The Sentinel Event Policy is employed to deal with significant critical events.

Facility inspections and corrective action

The Region does not have a policy or procedure in place to monitor compliance with standards or monitor trends in complaints and incidents.

To implement the recommendation, the Region needs to:

- develop and implement a comprehensive and ongoing process to monitor facilities' compliance with the standards,
- provide guidance to contracted facility operators on reporting and dealing with critical incidents and complaints,
- include requirements for compliance to standards in service provider contracts, and
- develop and implement a process to monitor trends in complaints and incidents for all facility, including contracted operators, to identify issues and possible non-compliance with standards.

Summary of audit results for Northern Lights Health Region (NLHR)

1. Systems to develop and maintain current standards—satisfactory progress

We recommended that the Department of Health and Wellness, working with the Regional Health Authorities and the Department of Seniors and Community Supports, update the Basic Service Standards for services in long-term care facilities and implement a system to regularly review and update the Basic Service Standards to ensure they remain current.

Standards for services

The Region has introduced the new care and accommodation standards and:

- performed a gap analysis for each of the Continuing Care Health Service Standards to identify areas for improvement,
- started to draft policies and procedures to comply with the new care standards,
- compared the Authority's accommodation standards and policies with the Long Term Care Accommodation Standards and the Supportive Living Accommodation Standards and concluded that no changes were required to the region's accommodation standards or policies.
- participates regularly in provincial working groups to interpret and implement the standards through the Continuing Care Leaders Council (CCLC), and
- is working with the Department of Health and Wellness and other Authorities to develop a common interpretation of the standards.

Changes to standards

The Region has participated in processes for providing input and suggestions for changes to standards by:

- providing feedback to the Department through the CCLC when they believe there should be a change in the standards.

Communication of standards

The Region communicated the new care standards to facilities by:

- distributing a brochure to all employees that described what the new standards mean, how the Region planned to implement the new standards, how changes would affect employees, training available, and where to go for further information,
- providing training sessions and training materials to facilities and staff on the new standards, and

- training staff in all facilities on the use of the Continuing Care Desktop, a software product that includes information on the standards, evidence, best practices, and links to a number of relevant information and education resources.

To finish implementing the recommendation, the Region needs to:

- include the results of the monitoring program and facility inspections when providing feedback on the care standards at the Continuing Care Leaders Council, and
- finish updating policies and procedures.

2. Systems to ensure compliance with standards—satisfactory progress

We recommended that the Department of Health and Wellness and the Regional Health Authorities, working with the Department of Seniors and Community Supports, improve the systems for monitoring the compliance of long-term care facilities with the Basic Service Standards.

Compliance with standards

The Region expects facilities to comply with the Continuing Care Health Service Standards and the Long-term Care Accommodation Standards. There are no contracted long-term care beds in the region, but the contract for designated assisted living services was updated April 1, 2007 to include a requirement for the facility to comply with the Continuing Care Health Service Standards.

Complaints and incidents

The Region has policies and procedures for dealing with complaints and incidents and a system for:

- collecting information on incidents using a computerized incident management system, based on concise definitions of critical incidents,
- training for staff members on the use of the incident management system,
- alerting responsible individuals of incidents, and
- following up on all outstanding complaints and incidents that are not cleared within the timelines specified in the policy, by a person responsible for that function.

Facility inspections and corrective action

To monitor compliance with the care standards, the Region:

- completed a compliance audit in 2006 on all facilities using the old care standards.
- completed a gap analysis in 2007 for the key standards and developed action plans to resolve the deficiencies identified. Follow-up and resolution of deficiencies is in progress.

- employed an informal process for the supportive living facility through regular visits by the NLHR Home Care Manager. The contract with this facility was updated April 1, 2007 to include a requirement to comply with the new care standards.
- maintains a computerized Incident Management System with the capacity to track and report by facility and type of incident. Managers can generate requests on an ad hoc basis.

The Regional Quality Assurance Committee (QAC) functions include the systematic identification of trends, setting of improvement goals and the development of strategies to achieve the goals. Reports and standing agenda items for the QAC include critical incidents and near misses.

To finish implementing the recommendation, the Region needs to:

- develop a standards compliance monitoring program that monitors all standards, and
- inspect facilities for compliance with the Continuing Care Health Service Standards and the Long-term Care Accommodation Standards, and establish processes to resolve non-compliance.

Appendix B—management actions on remaining 2005 recommendations

Management actions

Management of Alberta Health and Wellness (Health) and Alberta Seniors and Community Supports (SCS) reported to us the following progress on the remaining 2005 recommendations. We have not completed audits respecting this reported progress:

1. Effectiveness of services

Recommendation

We recommend that the Department of Health and Wellness and the Regional Health RHAs, working with the Department of Seniors and Community Supports, assess the effectiveness of services in long-term care facilities.

Health

Health has directed the RHAs to implement a set of tools for care assessment, planning and reporting. The tools have outcome measures and quality indicators to help in assessing the effectiveness of the systems. All RHAs plan to implement the tools by March 2009.

SCS

All RHAs will implement the InterRAI tool in their long-term care facilities. This is largely a Health matter and SCS will continue to support them.

2. Costing and accommodation rates

Recommendation

We recommend that the Department of Health and Wellness, working with the Department of Seniors and Community Supports, collect sufficient information about facility costs from the Regional Health RHAs and long-term care facilities to make accommodation rate and funding decisions.

Health

Projects underway include:

- Examining options for enhancing electronic reporting capabilities to collect information on accommodation related costs.
- Reviewing quarterly reports submitted by RHAs.
- Analysis and discussion with RHAs on paid hours of care in long-term care facilities.

SCS

- On October 1, 2007, Seniors increased the maximum long-term care accommodation rates by 5%.
- SCS is identifying options for setting and adjusting accommodation rates for the future.
- SCS has developed a Financial Costing Model to monitor and project accommodation service costs in long-term care and supportive living settings. Currently the model is being used in supportive-living settings; however, the possibility of using it in long-term care settings is being explored.

3. Information to monitor compliance with legislation

Recommendation

We recommend that the Department of Health and Wellness, working with the Regional Health RHAs and the Department of Seniors and Community Supports, identify the information required from long-term care facilities to enable the Departments and RHAs to monitor their compliance with legislation.

Health

Health, in collaboration with the RHAs, is developing electronic reporting systems to monitor the quality indicators that will be a product of the care assessment, planning and reporting tools that will be implemented by 2009.

Health has developed a framework to monitor compliance of long-term care facilities with the standards and legislation.

SCS

- March 2007, revised Long-Term Care and Supportive Living Accommodation Standards were released after additional consultation and feedback from stakeholders.
- Over 30 orientation sessions on the new accommodation standards were held for long-term care and supportive living facility operators in 9 locations across the province during March and April 2007.
- May 2007, the Nursing Homes General Regulation and the Coordinated Home Care Program Regulation were amended to require both RHAs and their contracted operators/agencies to comply with the health service standards. The amended Nursing Homes General Regulation also required RHAs and their contracted operators to comply with the long-term care accommodation standards.
- SCS is finalizing the monitoring process for long-term care facilities with each RHA. Monitoring visits will begin in November 2007.

4. Future needs and goals

Recommendation

We recommend that the Department of Health and Wellness, working with Regional Health RHAs and the Department of Seniors and Community Supports, develop a long-term plan to meet future needs for services in long-term care facilities. We also recommend that the Departments publicly report on progress towards goals in the plan.

Health

Health updated the Regional Continuing Care Projection Model, a tool to help the Department and RHAs in planning for future continuing care needs. Health analyzed the continuing care needs for each RHA and used their projections when evaluating the health plan submissions from the RHAs. All RHA health plans have been approved for the 2007 year. Health is finalizing the health factors for inclusion in the 2008–2011 health plan requirements.

SCS

- SCS has been given a mandate priority by the Minister to bring forward an updated plan to expand long-term care and improve standards of care. Ministry staff are working with stakeholders, Health and RHAs to develop this plan.
- Alberta Health and Wellness updated the Regional Continuing Care Model (RCCM) in August 2007 using more accurate population projections than those used in the previous run of the model.
- SCS is staging a planning session with private sector housing operators, world class experts, other stakeholders and Health to brainstorm new ideas for the continuing care system, and possible directions that the system can be taken in to meet the future needs of Albertans.

5. Assessing effectiveness

Recommendation

We recommend that the Department of Seniors and Community Supports improve the measures it uses to assess the effectiveness of the Seniors Lodge Program, and obtain sufficient information periodically to set the minimum disposable income of seniors used as a basis for rent charges.

SCS

- In 2006/07, over 90% of lodge residents were satisfied or very satisfied with their overall accommodations.
- SCS is exploring a project to evaluate the disposable income amount ($265) to determine if the amount is still appropriate.
- SCS is evaluating the effectiveness of the Lodge Assistance Program and is exploring other models that could challenge operators to be more competitive in the market and would promote choice for residents.

6. Determining future needs

Recommendation

We recommend that the Department of Seniors and Community Supports improve its processes for identifying the increasing care needs of lodge residents and consider this information in its plans for the Seniors Lodge Program.

SCS

- The Lodge Assistance Program Grant was increased to $11 ($7.50 through the Lodge Assistance Program and $3.50 through the Special Services Grant) per eligible resident per day to support lodge operators providing additional services as defined in the Seniors Supportive Living Framework.
- SCS consulted with management bodies to identify the scope of care needs of lodge residents. This information was considered when developing the eligibility criteria for the Special Services Grant to lodges. This grant helps pay the additional costs of special dietary requirements, housekeeping services and mobility assistance for residents requiring special care. The grant has increased from $2.50 to $3.50 per eligible resident per day in 2007.
- SCS is evaluating the effectiveness of the Lodge Assistance Program and is exploring other models that could challenge operators to be more competitive in the market and would promote choice for residents.

7. Information for benefit decisions

Recommendation

We recommend that the Department of Seniors and Community Supports obtain further information necessary to make income threshold, cash benefit and supplementary accommodation benefit decisions for the Alberta Seniors Benefit Program.

SCS

- A Project Charter outlining planned strategies and timelines has been developed.
- A Request for Information, identifying a three phase project, was developed and provided to the University of Alberta and the University of Calgary soliciting expert advice on developing complex models to predict the needs (including financial) of current and future seniors.
- The University of Calgary responded to the RFI with a proposal to "understand the income and expenditures of Alberta seniors". A contract has been awarded to the University of Calgary to complete this work.
- Ministry staff are in the process of working with these researchers to obtain relevant data on seniors' incomes and expenditures.
- It is expected that findings from phase 1 of this project will be available in June 2008.

Identifying and managing conflicts of interest for contracted IT professionals

1. Summary

Public complaint received

We received a public complaint about a Project Manager[1] at the then Ministry of Infrastructure and Transportation (Ministry). From April 2003 to March 2007, he managed the Transportation Infrastructure Management System (TIMS) project for the Ministry under a fee-for-service contract between the Ministry and a primary contractor.[2] From April 2007 to July 2007, he managed the same project under contract between his own private company[3] and the Ministry. He was not an Alberta government employee.

TIMS uses contracted professionals

TIMS is an information technology (IT) project that relies heavily on IT professionals working under contract for hourly professional fees rather than government employees working for a salary.

Allegation of IT Professionals paying a fee for every hour they work

The complainant alleged that the Project Manager required some IT professionals working under his supervision on the TIMS project to pay his private company a fee for each hour they worked on the project. The complainant also alleged that some IT professionals, unwilling to pay the Project Manager part of their professional fees, had their hours curtailed or their contracts cancelled.

Assessing credibility of complaint

We assessed the credibility of the complaint, and subsequently confirmed that five IT professionals were subcontractors of the Project Manager's private company, which retained a portion of their professional fees on an ongoing basis. However, we found no evidence that hours were curtailed or contracts cancelled, as alleged.

Lesson learned

The critical lesson to be learned from our work on this complaint is that even if contracts don't have conflict-of-interest clauses, or guidelines don't explicitly state what to do, the Government of Alberta's values expect anyone with knowledge of an apparent conflict of interest to report it so it may be acted upon.

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[1] Bruce Lewis

[2] The primary contractor was Connor & Filice Consulting Group Inc.

[3] Beltech Consulting Corp.

Sub-contracting relationships confirmed

Between April 1, 2003 and July, 2007, the Project Manager received approximately $225,000 per year for professional services for his duties as TIMS project manager. We also estimate that his private company received approximately $225,000 between April 2004 and July 2007 for its portion of professional fees paid to its subcontracted IT professionals working on the TIMS project. This situation was brought to the attention of senior management at the Ministry in 2006; however, the Ministry did not document any action.

Existing systems do not identify or manage potential conflicts of interest

We believe that these circumstances allowed for a potential conflict of interest between the Project Manager's private interests and his duties as a project manager. The contract for project management services stated:

> The Project Manager will work with the Project Sponsor and TIMS Business Team to select the other Project Team members. The Project Team is to be made up of IT Professionals who work under the direction and control of the Project Manager to complete the activities in the project plan and meet project objectives. Project Team members will have contracts directly with AT, but those contracts will be assigned to the Project Manager, to whom the Project Team members will be accountable for their performance.

As such, the Project Manager was responsible for the direction and control of IT professionals working on the TIMS project; and in addition to the fees he was receiving for those duties, his private company was receiving a portion of the fees paid to people reporting to, and directed by, him.

The systems to manage conflicts of interest could be improved

We concluded that the Ministry has a system to identify and manage conflicts of interest involving parties that contract directly with the Ministry. However, this system is not effective to identify and manage conflicts of interest for direct contractors' employees or subcontractors, who may actually perform the services. This led us to make two recommendations. We recommend that the Ministry:

Two recommendations

- in consultation with the Department of Justice, review and revise contracts for IT professionals, ensuring that there are adequate conflict-of-interest provisions with accompanying disclosure requirements, and
- improve its system for identifying and managing apparent or real conflicts of interest.

Systems to identify and manage potential conflicts of interest are required

Without a system to effectively identify and manage potential conflicts of interest, contractors may make decisions based on personal interest rather than the interests of the Ministry. This in turn may lead to inefficiencies and increased costs.

2. Audit objectives and scope

Our audit objectives

Our objectives were to determine if the Ministry had systems to effectively identify and manage apparent or real conflicts of interest for contracted IT professionals working on the TIMS project. Our work included examining the Ministry's response to prior allegations involving the Project Manager of TIMS. We did not perform a value-for-money audit on the TIMS project.

Our audit scope

The scope of our examination consisted of:

- interviews and examination of documents from current and former contracted IT professionals from the TIMS project.
- interviews with organizations providing contracted IT professionals to the Ministry.
- review of Alberta legislation and policy relating to conflicts of interest.
- interviews of Ministry personnel and examination of Ministry documents.

3. Understanding the systems

TIMS Project

Transportation Infrastructure Management System (TIMS)

TIMS is an integrated web-enabled system intended to support the Ministry's management of provincial highway infrastructure, using a variety of custom designed software applications. Generally speaking, TIMS provides the Ministry with the necessary knowledge to effectively manage and make decisions about the provincial highway network. For example, the Ministry has access to, among other things, information about structures such as bridges, including load capacity, and information about roadways and intersections, including traffic volume levels. This information allows the Ministry to plan and make decisions about ongoing maintenance requirements, and new infrastructure projects. TIMS began development in 1996 and was the subject of work by our Office during 1997[4] and 1998[4]. The project is still underway, although with a different scope. As at the date of our report, we were unable to verify information from the Ministry regarding the budget and costs to date, of the project.

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[4] *Annual Report of the Auditor General*, 1996-1997, page 192-194, *Annual Report of the Auditor General*, 1997-1998, page 191-193

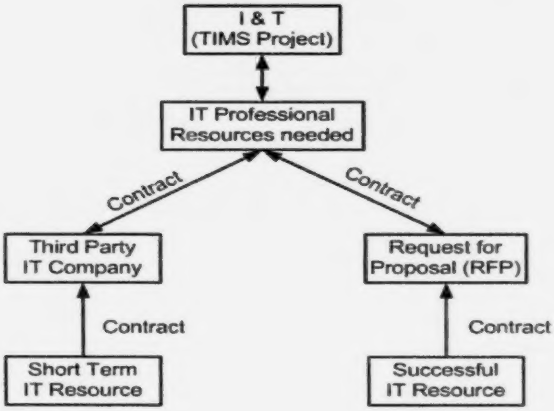
Obtaining Resources for TIMS

The Ministry obtains much of its IT professionals for the development and support of TIMS project applications from externally contracted sources. Contracts define the scope of work, remuneration, and desired outcomes.

The Ministry uses two ways to obtain resources for TIMS:

- a third party IT company supplies short term resources pursuant to a contract with the Ministry, and
- Request for proposals (RFP)—the successful party enters into a consulting agreement directly with the Ministry.

The contractual relationships between the Ministry and IT professionals are illustrated below:

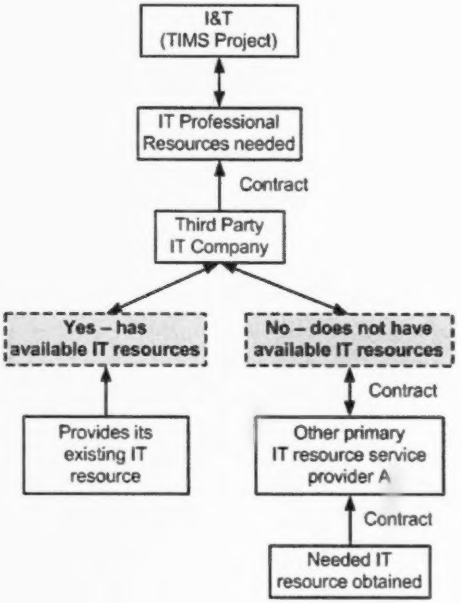

I & T
(TIMS Project)
IT Professional Resources needed
Contract
Contract
Third Party IT Company
Request for Proposal (RFP)
Contract
Contract
Short Term IT Resource
Successful IT Resource

Obtaining Resources from the third party IT company

If the Ministry identifies the need for an individual with specific skills for a short term basis, it advises the third party IT company. In such cases, it may not be cost effective or feasible to obtain resources through the Request for Proposals (RFP) process given the scope or timing of the work.

If the third party IT company does not have existing resources with the required skills, they may use other service providers to obtain the required resources. These other service providers have no direct contractual relationship with the Ministry; their agreements are with the third party IT company. Similarly, individuals supplied by the third party IT company to provide services for the Ministry do not have a direct contractual relationship with the Ministry.

These contractual relationships are illustrated as follows:


I&T (TIMS Project)
IT Professional Resources needed
Contract
Third Party IT Company
Yes – has available IT resources
No – does not have available IT resources
Contract
Provides its existing IT resource
Other primary IT resource service provider A
Contract
Needed IT resource obtained

Selecting Resources by RFP

For long term resources an RFP is issued. Proposals are reviewed by a selection committee and rated against various criteria. The selection committee compiles a report, including a recommendation to a contracts review committee, which makes a final decision.

The Ministry's expectations regarding disclosure and avoidance of potential conflicts of interest are set out in the contracts entered into with the service providers.

4. Conclusions

Audit-specific criteria

Criteria	Conclusion			Related Recommendations
	Met	Partly Met	Not Met	
Criterion # 1: Expectations for disclosure and avoidance of apparent and real conflicts of interest should be clearly defined and communicated to IT professionals who enter into fee-for-service agreements with the Ministry.		✓		#1
Criterion # 2: A system should be in place to identify and manage potential or actual conflicts of interest including sufficient reporting requirements to demonstrate the matter was dealt with.		✓		#2

Criterion #1 Expectations for disclosure and avoidance of conflict of interest

Overall conclusions

This criterion was partly met. Expectations are defined and communicated by the Ministry through conflict-of-interest provisions in current contracts entered into with resourcing IT companies or individuals. However, these companies or individuals are not contractually obligated to ensure that their employees or subcontractors who perform services for the Ministry comply with the Ministry's conflict-of-interest provisions.

Criterion #2 Identification and managing of conflicts of interest

This criterion was partly met. The Ministry has a system to identify and manage potential conflicts of interest for primary contractors. However, we believe the system is very informal and lacks guidance to staff. There is no effective system to identify and manage potential conflicts of interest involving employees or subcontractors of the primary contractor.

5. Recommendations

5.1 Identifying and managing conflicts of interest

Recommendation No. 5

We recommend that the Ministry of Transportation, in consultation with the Department of Justice, review and revise contracts for IT professionals, ensuring that there are adequate conflict-of-interest provisions with accompanying disclosure requirements.

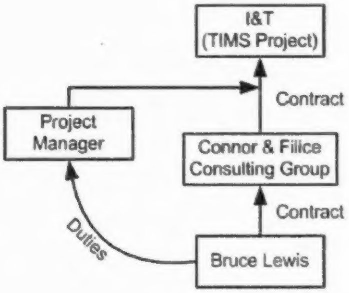
Recommendation No. 6

We recommend that the Ministry of Transportation improve its system for identifying and managing apparent or real conflicts of interest for contracted IT professionals.

Background

Public complaint received

In May 2007, a member of the public alleged to us inappropriate contracting practices involving the TIMS Project Manager. We were told that the Project Manager did not have a direct contract with the Ministry, but was the subcontractor of a third-party company that had a primary contract with the Ministry. The Project Manager received payment for his work as TIMS Project Manager from the primary contractor, not the Ministry. The following diagram illustrates this relationship:



We confirmed aspects of the complaint

In our initial examination, we confirmed the above relationships and identified five IT professionals working on the TIMS Project who were or had been subcontractors of the Project Manager's private company. Although the Project Manager reported to the Ministry's program director of TIMS, the contract for project management services provided that IT professionals working on the TIMS project, work under the direction and control of the Project Manager. This led us to examine the systems that the Ministry has in place for identifying and managing conflicts of interest.

Criteria: the standards we used for our audit

- Expectations on disclosure and avoidance of apparent and real conflicts of interest should be clearly defined and communicated to IT professionals who enter into fee-for-service contracts with the Ministry.
- A system should be in place to identify and resolve apparent and real conflicts of interest, including sufficient reporting requirements to demonstrate the matter was dealt with.

Our audit findings

The criteria were partly met.

Clearly defining and communicating expectations

Expectations not adequately communicated

Expectations for disclosure and avoidance of apparent or real conflicts of interest are set out in contracts the Ministry uses for IT services. However, the conflict-of-interest obligations apply to the contracting party, not to subcontractors actually performing the services. In many cases, the contractor is a corporation, and the person performing the services is a subcontractor to that corporation. Since the IT professional performing the services has no direct contractual relationship with the Ministry, they have no contractual obligation to disclose potential or actual conflicts of interest. They may also not be aware of expectations for conflict of interest because these are set out in a contract to which they are not a party. This situation existed with the Project Manager, who was a subcontractor to the primary contractor on the TIMS project.

All IT professionals should be aware of guidelines

The Ministry needs to ensure that all IT professionals providing services to the Ministry are aware of and bound by the Ministry's expectations about conflict-of-interest issues. It can accomplish this by requiring primary contractors to ensure their employees and subcontractors are familiar with and bound by similar obligations required of the primary contractor. We found this general requirement was present in other non-IT related consulting-service contracts used by the Ministry dated as recently as 2006.

Contracts should require subcontractors to comply

Contracts should provide the Ministry with assurance that subcontractors are aware of and will comply with conflict-of-interest guidelines. Systems could also be improved by developing guidelines that identify transactions that may lead to a conflict of interest, including defining related parties.

Identifying and managing potential conflicts of interest

No system for employees or subcontractors

Through contract provisions, the Ministry has a system to identify and manage potential conflict-of-interest situations for primary contractors but not for employees or subcontractors of primary contractors.

System is informal

The system in place is very informal. Management responds to allegations they receive in a manner that they consider appropriate in the circumstances. There is no protocol or guidance for them to follow and no requirement to document their actions.

Contracts for the TIMS project

Beltech received fee for each hour worked by IT professionals

The Project Manager's private company had contracts with five IT professionals providing services on the TIMS project and retained a portion of each hourly professional fee paid for these five IT professionals. As a result, we estimate payments totalling approximately $225,000 were paid to the Project Manager's private company between April 2004 and July 2007.

Four of these IT professionals were supplied to the TIMS project as short term professionals by EDS (Canada),[5] which in turn obtained these professionals from two other service providers, Procom[6] and Eagle Professional Resources Inc.[7]. The Project Manager's private company supplied these four IT professionals to Procom and Eagle under contract. These four IT professionals were paid their professional fees under individual contracts they had negotiated with the Project Manager for his private company. The following diagram illustrates this arrangement:

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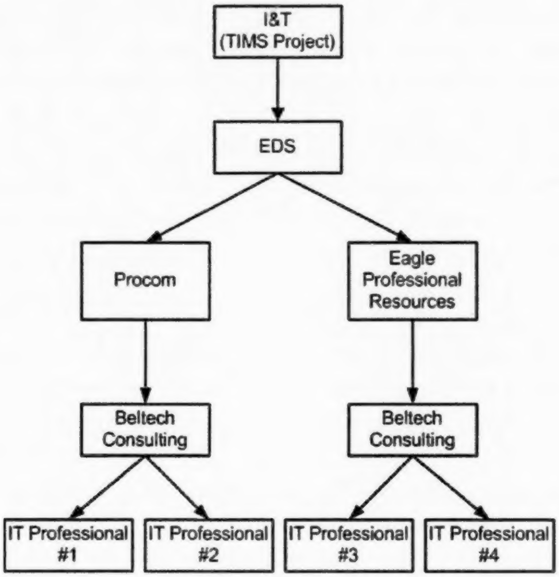
[5] EDS Canada supplied IT professional resources to the TIMS project under a Master Services Agreement with the Ministry during the period covered by our audit. They have since been replaced by another firm.

[6] Professional Computer Consultants Group (Alberta) Ltd.

[7] Procom and Eagle Professional Resources supplied IT professionals to EDS, which in turn supplied the Ministry under their Master agreement.


I&T
(TIMS Project)
EDS
Procom
Eagle Professional Resources
Beltech Consulting
Beltech Consulting
IT Professional #1
IT Professional #2
IT Professional #3
IT Professional #4

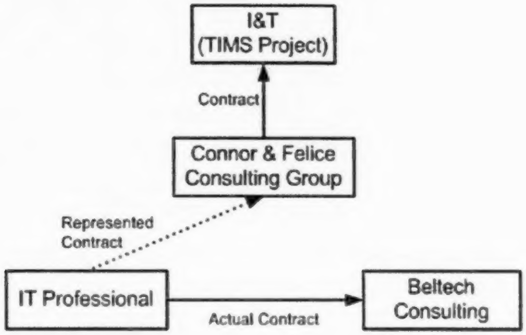
No inappropriate action by service providers

We found no evidence that EDS, Procom or Eagle Professional Resources acted inappropriately or knowingly supported the provision of IT professionals that resulted in apparent or real conflicts of interest.

Beltech and primary contractor each paid a fee for each hour worked by IT professional

The fifth IT professional associated with the Project Manager's private company was supplied to TIMS through an RFP by Connor & Filice (the TIMS primary contractor). This IT professional, however, was a subcontractor of the Project Manager's private company, which had entered into an arrangement with Connor & Filice, who in turn contracted with the Ministry to provide the services of this individual on the TIMS project. With this arrangement, both the Project Manager's private company and Connor & Filice received fees for every hour the IT professional worked on the TIMS project.

The following diagram illustrates this arrangement:



Project Manager duties

Project manager not obligated to disclose

From April 2003 to March 2007, the Project Manager worked under a contract between the primary contractor, Connor & Filice, and the Ministry. Under this arrangement, he was not contractually obligated to disclose any apparent or real conflicts of interest he may have been party to.

Disclosed subcontractor arrangements in June 2007

From April 2007 to July 2007[8], the Project Manager contracted directly with the Ministry to perform project-management duties. On June 4, 2007, the Project Manager disclosed to the Ministry that his private company had contracts with Eagle Professional Services and Procom to provide services to EDS.[9]

The Project Manager's responsibilities, as set out in the contract for project management services, included:

- working with the Ministry to ensure adequate IT professionals on the TIMS project,
- providing day to day direction to TIMS IT professionals,
- reviewing team member time reports, and
- making recommendations to the Ministry about performance and payment of selected IT professionals.

Project manager reviewed but did not approve timesheets

The Project Manager provided input into identifying IT professionals and determining future needs for the TIMS project. The Project Manager also reviewed time sheets for contracted IT professionals, including those subcontracted to his private company. There was, however, a secondary review of all time sheets by Ministry staff and approval for payment could only be made by the TIMS Program Director, to whom the Project Manager reported.

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[8] The Project Manager left the TIMS project in mid-July 2007.

[9] Letter dated June 2, 2007 from Beltech Consulting Corp to Alberta Infrastructure & Transportation.

No evidence Project manager favoured his resources

We found no evidence to suggest that the Project Manager acted improperly in approving time sheets or identifying resources for the project. However, these types of circumstances may put the Ministry at risk when someone is responsible for directing and controlling IT professionals with whom he has a financial interest. There is also a risk that the Ministry may not receive its best value for money if decisions regarding personnel resourcing of the project may be influenced by a person with undisclosed private financial interests in some of those same resources. The Ministry needs to ensure that all individuals or corporate entities providing services or resources to the project are required to disclose any relationships with other contractors or resources in order to reduce these risks.

Steps taken by the Ministry

We were unable to determine the extent to which Ministry officials were aware that there were contractual relationships between the Project Manager's private company and these five contracted IT professionals before the June 4, 2007 disclosure letter from the private company. We received differing recollections on discussions that had taken place.

Beltech proposed providing subcontractors in 2004 but was refused

We reviewed minutes of a Ministry contracts review committee meeting dated April 1, 2004 relating to an RFP for IT professionals. The Project Manager's private company submitted three IT professionals for consideration in this RFP. The contracts review committee concluded that the Project Manager assisted in development of the original RFP and therefore was in a conflict of interest on this competition because his proposed resources could be perceived as having an unfair advantage.

The committee further concluded that if his nominees were successful, the Project Manager would be directing the activities of his private company resources, and it would be reasonable to perceive that he could be in a position to benefit personally from this, and, as such, a conflict of interest would exist. The committee concluded that his private company could not provide IT professionals to the project and the Project Manager was so informed.

Beltech arranged with another company to use his subcontractors for a fee

Nevertheless, the Project Manager's private company entered into an arrangement with Connor & Filice respecting one of the proposed IT professionals, who remained contractually bound to the Project Manager's private company. Connor & Filice then provided this same resource to the Ministry.

We interviewed the Project Manager. He confirmed the contractual relationships he had with these five different IT professionals working on the TIMS project. He also told us that he did not view these arrangements as conflicts of interest, and advised that it is industry practice to have these types of subcontracting relationships.

Ministry was told of apparent conflict in 2006 but actions taken are not clear

We interviewed several Ministry personnel. We were told that in 2006, the Ministry learned of a potential conflict of interest involving the Project Manager and a contracted IT professional. Some steps were apparently taken to investigate this matter but we could not conclude on their effectiveness due to vague recollections by Ministry staff and a complete absence of any documentation detailing actions taken. In any event, the Project Manager continued from 2004 to 2007 to direct individuals on the TIMS project who were subcontractors of his private company.

Clear guidelines required

Guidelines needed to assist in managing alleged conflicts of interest

The difficulties we encountered in determining the appropriateness of the Ministry's response to the 2006 allegation concerning the Project Manager demonstrate the need for an improved system for identifying and managing potential conflicts of interest. The Ministry needs a system that sets out guidelines for staff in dealing with these matters, including documentation of actions taken. This will increase accountability of the system and provide a means to better evaluate decisions made and actions taken in resolving the matter.

Implications and risks if recommendation not implemented

The Ministry may not be aware of apparent or real conflicts of interest between the private interests of IT professionals and their duties to the Ministry. There is also a risk that the Ministry may not receive the best value for money from a contract if IT professionals make decisions based on their private interests.

Without a clear process for reporting and investigating potential conflicts of interest, Ministry staff may not handle or respond to allegations consistently and thoroughly. Such a process also ensures there is increased accountability on the Ministry to act on such allegations. As well, the Ministry's failure to investigate or act on allegations of impropriety may also result in the perception that this type of conduct is acceptable.

Monarch Place

1. Summary

Public complaint about the Society

We received a public complaint about Innovative Housing Society of Canada (Society)[1] selling Monarch Place, an affordable housing project in Red Deer, Alberta. The Society had received grant funding from the government of Alberta to construct the project and the continued availability of affordable housing in the project was uncertain.

Department has adequate systems

We examined the grant funding transaction between the Department of Municipal Affairs and Housing (Department)[2] and the Society for Monarch Place. Our objectives were to determine if program goals were met, public funds were protected, and the contract was monitored adequately. We conclude that the Department had adequate systems to ensure the Monarch Place grant was disbursed in accordance with program goals, and public funds were protected.

Department now provides funding to municipalities

No recommendations

Beginning in 2007–2008, most funding for affordable housing programs will be provided to municipalities, which will in turn enter into funding agreements with third parties.[3] The Department believes that municipalities are in a better position to evaluate and monitor grant recipients. Accordingly, we make no recommendations to the Department.

Operating shortfall from the beginning

The Society received a $1.3-million affordable-housing grant from the Department in January 2004 to construct Monarch Place. The facility opened in the spring of 2005 and experienced an operating deficit from the beginning.

Shortfalls responsibility of grant recipient

Monarch Place sold: new owner not providing affordable housing

In December 2006, the Department informed the Society that operating deficits were the responsibility of the recipient, as specified in the funding agreement, which was a capital-based initiative not allowing for operating expenses. With no available business solution, the Society sold Monarch Place. The new owner decided not to provide housing under the terms of the funding agreement, and the grant funds became repayable. We found no evidence that the Society operated outside of the terms and conditions of the affordable housing grant.

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[1] Formerly Handicapped Housing Society of Alberta

[2] Formerly Ministry of Seniors and Community Supports.

[3] Approximately 93% of grant funding will be directed to municipalities for 2008-2009

2. Audit objectives and scope

Funding arrangement between Department and Society

Our objective was to determine if the Department's handling of the Monarch Place project ensured program goals were met, public funds were protected and the contract was adequately monitored. Our scope was to review the program objectives and goals, examine the Monarch Place funding agreement, and interview Department staff, Society personnel and other parties. We did not audit the Society's books and records.

3. The affordable housing program

Housing programs started in 2002

Department wants to partner with third parties

In 2002, the Government of Canada announced a $680 million affordable housing program for Canada. Alberta's share was about $67 million. The program required affordable housing units to be available for 10 years and rent to be at least 10% below average market rents. The Alberta government matched the program funding of $67 million, for a total of roughly $134 million. Alberta also doubled the time that the units had to be available, from 10 to 20 years. The Department administers this program, called the Affordable Housing Program Initiative (AHPI). One of the Department's objectives is to provide affordable housing in partnership with third parties.

Concept started with local citizens

Responsibility turned over to Society in 2003

In 2001, several Red Deer residents formed the Monarch Housing Board to develop an affordable housing project. The Red Deer community responded by providing financial commitments in various forms. The Board soon realized it needed a partner to operate and manage the proposed facility, to be called Monarch Place. The Board turned over the task of developing and managing Monarch Place to the Society in the spring of 2003.

Society awarded $1.3-million grant for 26 affordable housing units in a 65-unit building

The Society applied for an AHPI grant in April 2003 and was awarded $1.3 million in January 2004 for 26 units in the Monarch Place project. One of the funding conditions was that the affordable housing units had to be at 10% below average market rents for 20 years. In the spring of 2005, the 65-unit facility opened. It consisted of 26 affordable housing units (to be rented at below-market rents), 20 transitional units (for families in need) and 19 units (to be rented at market rents).

4. Conclusion

Society operated within terms and conditions of grant

We found no evidence that the Society operated outside of the terms and conditions of the affordable housing grant. The Society experienced financial difficulties upon opening Monarch Place. With no available solution, the Society sold the property through a real estate agent to a third party, not affiliated with the Society. The sale triggered a repayment process under the funding agreement, which is currently underway. Any further development by the new owners is beyond the relationship between the Society and the Department, and therefore beyond the scope of this audit.

5. Audit findings

5.1 The application process

Detailed proposal submitted in support of application

The supporting documentation for the AHPI grant application consisted of a detailed proposal submitted by the Society for the Monarch Place project. The detailed application included the target client group, community needs, projected finances, permanent financing, projected pro-forma, financial statements and development timetable. The Department approved the application after examining it for reasonableness.

5.2 The contract

Contract had usual conditions for AHPI grant

Once the AHPI application was approved, the Department and the Society signed a contract for $1.3 million for 26 affordable housing units. The contract stipulated that the affordable housing units had to be maintained for 20 years and that the rent had to be at least 10% below average market rent. The contract's termination clause stated that if the program requirements were not met, the balance of the grant had to be repaid to the Minister. The balance outstanding declined 5% for each year of operation. Any operating shortfall was the responsibility of the recipient.

5.3 The construction process

Funding process followed normal procedures

The grant funding provided to the Society followed the Department's standard procedures. Initially, the Society received 50% of the grant funding to start the construction of the building. The contractor submitted a progress report at the 50% completion stage to draw another 40% of the funding. A certificate of substantial completion with audited financial statements for the project was provided to the Department allowing it to release the final 10% of the grant funding. The project was initially forecast to cost $5.8 million, but ended up with an overrun of about $600,000, for a final cost of $6.4 million. We did not investigate the cause of the cost overrun.

5.4 Financial difficulties

Society faced unexpected operating expenses

The Society told us the project faced financial challenges from the beginning of operations, due to:

- increased live-in management expenses,
- unanticipated municipal property taxes,
- lower-than-budgeted occupancy rates, and
- additional long-term debt borrowing costs due to construction overruns.

5.5 Meeting the Department

Department and Society met to discuss options

In December 2006, the Society, at their request, met with the Department officials to discuss the operating shortfall. They could not reach a solution. There was no discussion on alternative strategies. The Society told the Department they would have to consider all their options in trying to solve the problem.

5.6 Sale of property

Society sold property to an unrelated third party

Society owes $1.17 million to Department

Facing the continuing operating deficit, the Society decided in January 2007 to sell the building and listed it with a real estate agent. The real estate agent stated that the property was sold at fair market value to a third party. The transaction for $6.8 million was conducted at arms length. The new owners were not contractually obligated (and decided not) to assume the terms and conditions of the original agreement between the Department and the Society. This terminated the contract, requiring the Society to repay the entire grant, less the yearly allowance of 5%. When the contract ended, the Society owed the Department $1.17 million.

IT control framework

1. Summary

Alberta government relies on IT to deliver programs and services

The Alberta government relies extensively on information technology (IT) systems to deliver programs and services efficiently to Albertans and to process their financial and personal information, as well as its own. IT systems let government departments and organizations deliver programs more efficiently, and swiftly process large volumes of financial and other program data.

The importance of IT and IT controls

IT brings risks, along with benefits

Mitigating risks with controls is essential

As the balance shifts even more from manual to automated environments, IT control environments play an ever-increasing role in the overall internal control environment. Along with its benefits, however, technology introduces new risks and challenges. How can organizations efficiently and effectively deal with these risks and still maintain an environment to ensure the confidentiality, integrity and availability of their key information and systems? They can achieve this by implementing a set of well-designed and effective control processes or activities—in effect, by following a control framework.

IT control framework organizes controls to maximize benefits and minimize risks

IT control frameworks give management and users generally accepted measures, indicators, processes, and best practices to maximize IT benefits and minimize risks. An IT control framework, properly implemented, can effectively align business risks, technical issues, and control requirements. It helps organizations:

- better match their IT activities to their business needs
- fulfill their responsibilities for a sound internal control environment
- show—to regulators, business partners and customers—their commitment to put into practice and maintain an effective control environment
- show that they have operational, well-maintained, efficient, and cost-effective controls—and that IT is aligned with organizational business objectives
- clarify ownership, responsibilities and accountabilities within IT
- ensure that all stakeholders, within and outside of IT, have a common understanding of IT's mandate and responsibilities
- ensure that management understands IT's role and relevance in the organization
- ensure that management can meet its quality, fiduciary and security requirements

Managing risk is key to delivering programs and services efficiently and safely

Government must do more to manage risks

Most successful organizations understand the value of IT and use it to their benefit. They recognize the critical dependence of many business processes on IT, the need to comply with increasing regulatory demands, and the benefits of managing risks effectively. As a result, many publicly-listed and private companies have embraced IT control frameworks for efficiency in delivering cost effective goods and services and achieving regulatory compliance. Likewise, Albertans expect government departments to safeguard the confidentiality and accuracy of their personal information, to have effective and efficient controls so that services are not interrupted, and to protect public assets from misuse and fraud.

Alberta Government needs to better identify and mitigate IT risks

Departments have control processes but no department has done enough

Government departments as a whole need to do a better job identifying risks to their systems and data. Then they need to implement well-designed, efficient, and effective IT controls to mitigate these risks and provide secure services and programs to Albertans.

While all departments have IT control processes and activities to some extent, the controls differ significantly in design and effectiveness. For instance, the departments of Advanced Education and Technology, Education, and Energy have better IT controls than other departments as a result of their efforts in adopting an IT control framework. Other departments have implemented control processes without using an IT control framework. Upon examination of these efforts, we concluded that often the controls were ineffective or, at best, inefficient. We have summarized our findings on page 174. Overall, no department has an adequately documented and effective IT control framework in place.

Control framework as cost-effective insurance

The work needed at different departments to implement efficient and effective IT controls differs significantly. But an IT control framework is inexpensive "insurance" for all departments against the risks of poorly designed and ineffective controls.

Government spends a lot on IT

IT controls not expensive or onerous

The government, through all its departments and agencies, has invested significantly in IT systems and infrastructure. To get maximum benefit from IT systems, and to ensure they are adequately secured, the government needs to institute controls in an orderly fashion. This process does not have to be onerous, time consuming or expensive. The cost of adopting a control framework is, in itself, not high. The cost increases only as specific controls are implemented. And, a disciplined approach requires organizations conduct a risk assessment, determine their exposure to risks, quantify the costs of mitigating them, and then implement controls *only* if they are cost effective—for example it is not cost effective to implement a control costing $10,000 to safeguard an asset worth $1,000.

Guidance on control frameworks missing

No guidance for developing and implementing efficient and effective IT controls exists in the Government of Alberta (GOA). The Ministry of Service Alberta (Service Alberta) can play a key role in improving the GOA's overall control environment by helping develop guidelines for IT control environments. These guidelines can improve the GOA's overall security by increasing IT security awareness, and developing efficient control processes.

Service Alberta can give key guidance

Service Alberta and CIO Council tackling the problem

Service Alberta recognizes the lack of guidance and is leading an initiative, through the CIO Council, to develop and implement a benchmark IT governance and control framework based on COBIT, an industry-recognized best practice IT control framework. This initiative will include guidance to departments to adopt and implement an IT governance and control framework. Service Alberta, in conjunction with the CIO Council, plans to develop and promote these IT control guidelines, and to make this guidance available to all departments by March 31, 2009.

Our monitoring to continue

We support Service Alberta's initiative and will continue to monitor its progress. We will also monitor the initiatives government departments are taking in the absence of definitive guidance, and to draw the government's attention to poor or non-existent IT control environments.

Control weaknesses and related risks

Without proper control frameworks, government managers cannot do—or assert that they are doing—everything necessary to minimize the risks of loss and theft of data, inaccurate, unreliable, and unavailable data, and wasted resources.

2. Audit objectives and scope

Scope

General computer controls tested

We routinely test the IT general computer controls of all government departments, agencies, boards, commissions, and public-sector post-secondary institutions as part of our annual financial statement audits. This report summarizes the results of our audits of Service Alberta and other Alberta government departments done between April 01, 2006 and January 31, 2008. These findings should, however, interest all government organizations.

Objectives

Do departments have adequate IT control frameworks?

1. Do departments have a set of well-designed, efficient, and effective IT control processes—the result of using an IT control framework—to effectively mitigate risks to their information and computer systems? Such a framework also helps the efficiency and effectiveness of business processes and management oversight, so departments can give Albertans efficient, reliable, and secure services.

Do they assess and control IT risks?

2. Have departments adequately assessed the risks to their information and IT systems, and then designed and implemented adequate mitigating controls?

Is the right guidance available?

3. Is necessary guidance available for departments to implement and maintain an IT control environment that meets industry best practice standards?

3. Conclusions

No control frameworks

1. Departments do not have adequate IT control frameworks to effectively mitigate risks to their information and computer systems.

IT risks not assessed

2. Departments have not adequately assessed the risks to their information and IT systems.

No guidance available

3. Necessary guidance is not available for departments to implement and maintain an IT control environment that meets industry best practice standards.

4. Recommendation

Guidance to implement IT control frameworks

Recommendation No. 7

We recommend that the Ministry of Service Alberta, in conjunction with all ministries and through CIO Council, develop and promote:

- **a comprehensive IT control framework, and accompanying implementation guidance, and**
- **well-designed and cost-effective IT control processes and activities.**

Background

Control framework key in controlling information and systems, maximizing benefits and minimizing risks

An IT control framework, such as Control Objectives for Information and related Technology (COBIT), is a key element in ensuring proper controls over an organization's information and the systems and processes that create, store, manipulate, and retrieve important data. COBIT is an industry-recognized best practice IT control framework developed and maintained by the IT Governance Institute. It gives senior management and IT users generally accepted measures, indicators, processes, and best practices to maximize IT benefits and minimize risks.

Control framework also helps program and service delivery

An IT control framework is also the best way to ensure the efficiency, economy, and effectiveness of IT processes to provide secure services and programs to Albertans and mitigate identified risks. If the security or integrity of these IT systems is compromised, it can impair the accuracy of an organization's financial information, resulting in wasted effort and cost in providing services to Albertans.

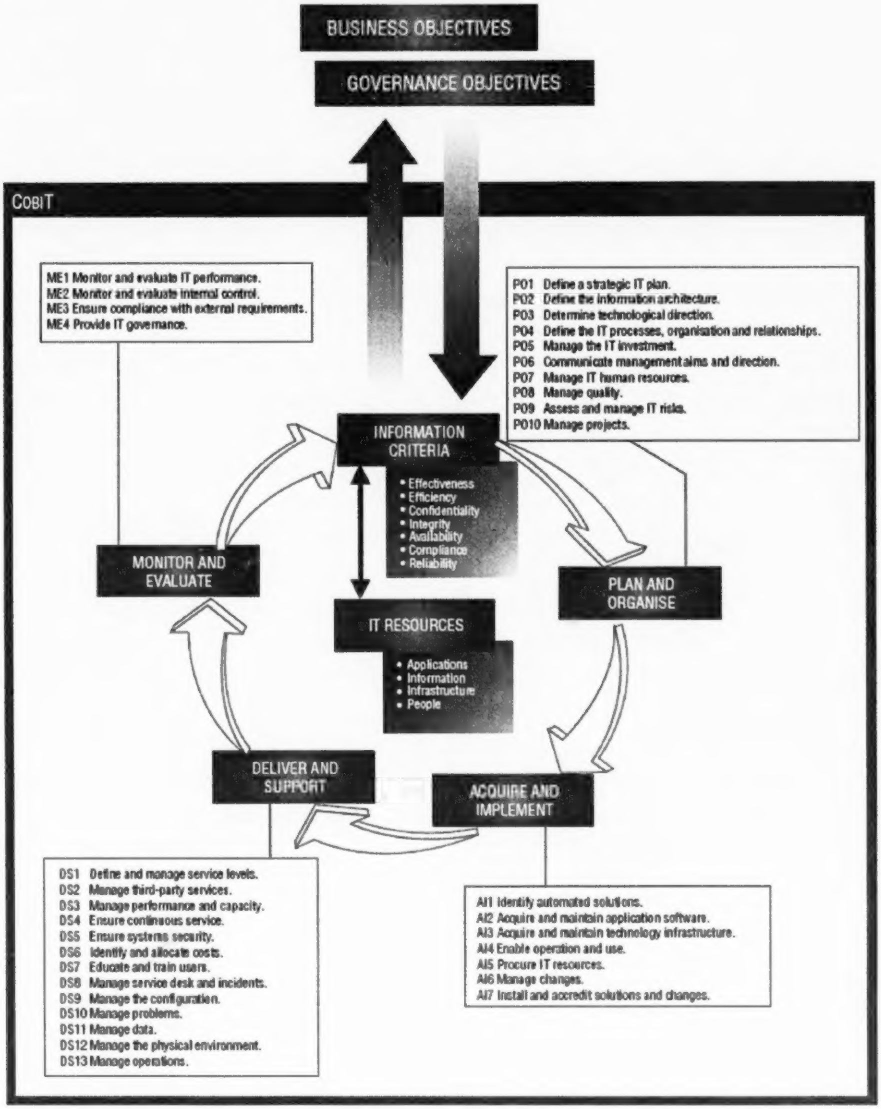
Without comprehensive IT control frameworks and effective IT control activities, departments cannot effectively mitigate risks to the following key areas:

- Confidentiality—protection of sensitive information from unauthorized disclosure
- Integrity—accuracy and completeness of information
- Availability—information is available as and when required
- Reliability—management can rely on information to operate the entity and exercise its financial and compliance-reporting responsibilities
- Effectiveness—information is relevant to the organization and delivered in a timely, correct, consistent and usable manner
- Compliance—with relevant laws, regulations and contractual arrangements
- Efficiency—information provided through optimal (most productive and economical) use of resources

COBIT framework

The COBIT Framework is a set of 34 high-level control objectives organized into 4 domains as illustrated below (COBIT 4.1 Edition Framework). The COBIT framework can be adopted in whole, or customized or scaled down to suit each department. It does not have to be expensive to implement a control framework. The cost of adopting a framework is, in itself, not high—the cost increases only as necessary, cost-justified controls are implemented.

Overall COBIT Framework[1]


BUSINESS OBJECTIVES
GOVERNANCE OBJECTIVES
COBIT
ME1 Monitor and evaluate IT performance.
ME2 Monitor and evaluate internal control.
ME3 Ensure compliance with external requirements.
ME4 Provide IT governance.
PO1 Define a strategic IT plan.
PO2 Define the information architecture.
PO3 Determine technological direction.
PO4 Define the IT processes, organisation and relationships.
PO5 Manage the IT investment.
PO6 Communicate management aims and direction.
PO7 Manage IT human resources.
PO8 Manage quality.
PO9 Assess and manage IT risks.
PO10 Manage projects.
INFORMATION CRITERIA
• Effectiveness
• Efficiency
• Confidentiality
• Integrity
• Availability
• Compliance
• Reliability
MONITOR AND EVALUATE
PLAN AND ORGANISE
IT RESOURCES
• Applications
• Information
• Infrastructure
• People
DELIVER AND SUPPORT
ACQUIRE AND IMPLEMENT
DS1 Define and manage service levels.
DS2 Manage third-party services.
DS3 Manage performance and capacity.
DS4 Ensure continuous service.
DS5 Ensure systems security.
DS6 Identify and allocate costs.
DS7 Educate and train users.
DS8 Manage service desk and incidents.
DS9 Manage the configuration.
DS10 Manage problems.
DS11 Manage data.
DS12 Manage the physical environment.
DS13 Manage operations.
AI1 Identify automated solutions.
AI2 Acquire and maintain application software.
AI3 Acquire and maintain technology infrastructure.
AI4 Enable operation and use.
AI5 Procure IT resources.
AI6 Manage changes.
AI7 Install and accredit solutions and changes.

Control processes explained

IT control processes are specific activities that help achieve identified control objectives. People or systems perform them to ensure business objectives and processes are met. They are an important subset of a department's overall internal control practices, and are most effectively determined by following an IT control framework. IT controls in a framework are commonly organized in three groupings:

- IT entity-level controls—deal with IT risk, strategy, and oversight

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[1] Source: COBIT 4.1. ©1996-2007 IT Governance Institute. All rights reserved. Used by permission.

3 groupings of controls

- IT general controls—include controls over the IT environment, computer operations, access to programs and data, program development and changes, IT continuity and the security of data
- IT application controls—refer to transaction processing controls, sometimes called "input-processing-output" controls

A successfully managed IT control framework has a documented, well-designed set of control activities to protect the confidentiality and security of information and to ensure that systems are available when needed. Effective management practices also monitor and measure the effectiveness of controls in an IT control framework to ensure that they function as designed.

Criteria: the standards we use for our audit

- Service Alberta should develop, and make available to departments, adequately documented guidelines on implementing IT control frameworks.
- Departments should implement well-designed and cost-effective IT controls and processes.

Our audit findings

Guidance on IT control framework missing

IT control frameworks missing

Guidance does not exist on a recommended framework. In addition, no department has an overall well-designed IT control framework, or has completely implemented well-designed and cost-effective IT controls and processes. Thus, we routinely make recommendations to auditees in our public reports to improve their IT controls. New or repeat recommendations made directly to departments' IT management in our *October 2007 Public Report* follow:

Recommendations to departments in *October 2007 Public Report*

Department	Volume 2	Recommendation
Employment, Immigration, and Industry	page 60 - 1.5	• Develop service-level agreements with information technology service providers that clearly define expected services; • Establish processes to obtain assurance that these service providers consistently meet service level requirements and that control activities performed by the providers are operating effectively.
Finance	page 87 - 1.3 page 93 - 1.6.3	• Tax and Revenue Administration Division—ensure that controls over Ministry information assets hosted by or administered by third party service providers are documented and operating effectively. • Alberta Investment Management—establish access and change-management controls for its investment-related computer information systems.
Health and Wellness	page 105 - 1.1 page 106 - 1.2 page 107 - 1.3	• Improve procedures to enforce and monitor compliance with Information Security Policy. • Obtain regular assurance that outsourced information and technology is properly controlled. • Improve access and change-management controls in Claims Assessment System.
Justice and Attorney General	page 128 - 1.1 page 129 - 1.2 page 130 - 1.3 page 131 – 1.4	• Develop and document Information Technology security policies. • Document and test disaster-recovery plans for all Information Technology systems. • Improve access controls over its information systems by: o reviewing user access rights regularly, and o adopting strong password controls. • Improve controls over the Civil and Sheriff Entry system by developing, documenting and implementing Information Technology security policies consistent with the guidance in the "Blueprint for the Security of Judicial Information".
Municipal Affairs and Housing	page 138 - 1.2 **Repeated**	• Approve draft security policies and implement procedures so only authorized users can access its systems and data. • Implement risk-assessment framework to manage information technology risks, and • Obtain independent assurance on outsourced computer general control environment.
Seniors and Community Supports	page 143 - 1.1	• Improve general computer controls by: o identifying and protecting data based on its sensitivity, o following change management procedures, o reviewing database logs, and o reviewing user access to applications.
Service Alberta	page 146 - 1.1 page 148 - 1.2 **Repeated** page 149 - 1.3	• Work with client ministries to revise information technology service-level agreements to: o ensure that agreements are current o clarify the level of services provided in each service category o define the roles and responsibilities of each party • Ensure that the systems it administers comply with Alberta government standards for computer security. • Regularly do risk assessments for data centre assets key to providing critical services.
Solicitor General and Ministry of Public Security	page 154 - 1.1 page 155 - 1.2	• Improve change-management process to include changes to information technology environment made by service providers. • Develop procedures to implement its business continuity plan to ensure it can recover its information technology operations within required timeframes in a disaster.
Tourism, Parks, Recreation, and Culture	page 172 - 1.1	• Work with Service Alberta to: o document the services that Service Alberta is to provide and its control environment for information technology o implement a process to ensure that Service Alberta consistently meets service level and security requirements o provide evidence that control activities maintained by Service Alberta are operating effectively

Departments may have implemented, or plan to implement, these recommendations. In due course, we will assess whether recommendations have been implemented.

Overarching problems and needs

Variance in identifying and controlling risks

- Significant differences exist in how departments identify risks to their environment and implement control processes and activities to mitigate the risks (ranging from no risk assessment to using an established risk assessment methodology).

Framework and its implementation not understood

- The majority of departments do not understand what an appropriate IT control framework is and how best to implement one to increase the efficiency and security of services to Albertans.

Common approach needed

- Departments need a common approach to identify risks and implement an IT control framework to mitigate risks.

Service Alberta aware of problems and working to solve them

Service Alberta and the CIO Council have identified a need for consistent standards and a common IT governance and control framework. They recently started developing a standardized IT control framework to meet this need. Two ministries have provided the CIO Council's Governance Committee with their proposed IT governance and control frameworks. CIO Council would own the proposed IT control framework, while Service Alberta would maintain and manage it, and communicate changes to all departments. Service Alberta agrees that—in conjunction with CIO Council—a system or process is needed to:

- develop a common IT control framework and IT control process standards.
- manage changes to the IT control framework.
- communicate changes in the IT control framework to organizations.
- educate staff on implementing and consistently following the framework.

Target of March 31, 2009

Service Alberta, in conjunction with CIO Council, plans to develop these systems and processes by March 31, 2009.

Implications and risks if recommendation not implemented

Without an adequate IT control framework, departments cannot:

Unable to meet goals, mitigate risks, provide secure services

- know—or show they know—the risks to their information systems and data.
- implement efficient and cost-effective IT controls to effectively mitigate unknown risks—or ensure they meet all their business goals efficiently and effectively.
- rely on their data, applications, or systems to provide complete, accurate, timely and valid information or services to Albertans.

Inadequate IT controls can expose the government to unnecessary risks

A lack (or an inadequate set) of IT control processes and activities can lead to:

- Albertans' personal data being lost, improperly accessed or altered
- government systems being breached
- poorly planned or defined projects, resulting in wasted resources due to lack of project ranking, duplicate or redundant tasks or projects, or discontinued projects
- unnecessary costs of operational errors, remediation or lost revenues
- increased service costs due to down time or disaster recovery events
- services Albertans rely on being unavailable when needed
- regulatory non-compliance
- implementation of systems or applications that do not work as expected or provide the expected benefits to Albertans

Financial statement and other assurance audits

Advanced Education and Technology

This chapter includes the results of our annual financial statement audits of public colleges, technical institutions and their related entities for their year ended June 30, 2007, which we completed since our October 2007 report. Our October 2008 report will include the results of the financial statement audits of Alberta's four Universities, the Ministry of Advanced Education and Technology, Department of Advance Education and Technology and the Access to the Future Fund. These entities have a March 31, 2008 year end and our work will be completed by July 2008.

Summary: what we found in our audits

- Alberta College of Art and Design
  The College should improve its:
  - processes and controls to increase efficiency, completeness, and accuracy in financial reporting—see page 180.
  - payroll controls by properly segregating payroll processing duties and implementing controls for processing manual cheques—see page 182.

- Grande Prairie Regional College
  We repeated our recommendation that the College improve its financial processes and controls over financial reporting to increase efficiency in preparing accurate internal and external financial reports—see page 183.

  The College should also improve its processes and controls over capital assets—see page 184.

- Grant MacEwan College
  The College should improve its systems to:
  - manage and report inventories.
  - monitor and account for the use of petty cash—see page 186.

- Portage College
  The College should develop guidelines and procedures for review and approval of fuel purchases on fuel purchase cards—see page 189.

Performance reporting

- Post-secondary institutions and other entities
  Our auditor's reports on the financial statements of post-secondary institutions listed in the Scope section are unqualified—see page 180.

Scope: what we did in our audits

Other entities that report to the Minister

We audited the financial statements for the year ended June 30, 2007 of the following entities:

- Alberta College of Art and Design
- Bow Valley College
- Grande Prairie Regional College and its related entity Grande Prairie Regional College Foundation
- Grant MacEwan College and its related entity Grant MacEwan College Foundation
- Keyano College
- Lakeland College
- Lethbridge College and its related entity Lethbridge Community College Fund
- Medicine Hat College and its related entity Medicine Hat College Foundation
- Mount Royal College and its subsidiary/related entities Mount Royal College Day Care Society and Mount Royal College Foundation
- NorQuest College and its related entity NorQuest College Foundation
- Northern Alberta Institute of Technology and its related entities the Northern Alberta Institute of Technology Foundation and Fairview College Foundation
- Northern Lakes College
- Olds College
- Portage College
- Red Deer College
- Southern Alberta Institute of Technology

Our audit findings and recommendations

1. Alberta College of Art and Design

1.1 Financial reporting and year-end processes

Recommendation

We recommend that Alberta College of Art and Design improve its processes and internal controls to increase efficiency, completeness, and accuracy in financial reporting.

Background

Management must prepare accurate financial statements

Management is responsible for preparing financial statements and accompanying notes in accordance with Canadian generally accepted accounting principles and ensuring effective internal controls over financial reporting. The Finance area is responsible for preparing the financial statements.

Criteria: the standards we used for our audit

The College should have documented and effective processes and controls over preparing accurate financial statements and reporting financial information to the College's senior management and Board.

Our audit findings

Management did not produce timely, accurate and complete financial statements

The College did not produce accurate and complete financial statements within scheduled timelines. We started our year-end audit of the June 30, 2007 financial statements on September 17, 2007. As at October 19, 2007, we still had not received complete and accurate financial statements.

Improvements needed:

- Properly code and review transactions
- Use available capital asset system
- Review working papers
- Automate preparation processes

The College could improve the effectiveness and efficiency of its financial statement preparation process in several ways, including:

- properly coding and sufficiently reviewing transactions when Finance staff enter them into the general ledger. The Manager, Financial Operations spends significant time at year end reviewing accounts to ensure transactions are appropriately recorded.
- using its capital asset system to record and track capital asset information. For 2006–2007, Finance staff did not use the capital asset system but instead used manual spreadsheets to record and track capital assets.
- reviewing the financial statement working papers to ensure they are relevant and useful, that information is easy to follow and not duplicated in the working papers.
- determining how it can automate the financial statement preparation process. The current process is time consuming and prone to errors because of extensive reliance on manual processes.

Implications and risks if recommendation not implemented

Without efficient and effective processes, the College may not produce timely, accurate, and complete financial reporting at a reasonable cost and the Board and senior management may not have appropriate information to make decisions.

1.2 Payroll controls

Recommendation

We recommend that Alberta College of Art and Design improve its payroll controls by properly segregating payroll processing duties and implementing controls for processing manual cheques.

Background

Contracted service provider processes payroll transactions

The College's largest expense ($10 million or 60% of total expenditures) is for payroll and benefits. The College's payroll department enters payroll data for salary and casual employees in the payroll system, creates, and transfers files to an outside service provider. The service provider calculates the payroll, including gross pay, source deductions and net pay. The service provider pays College employees their net pay via electronic funds transfer or cheque.

Criteria: the standards we used for our audit

The College should have effective internal controls to ensure only authorized employees are paid, they are paid based on approved rates, and in accordance with College policies and procedures.

Our audit findings

We found the following significant internal control deficiencies in the College's payroll processing function:

No payroll policies

- No policies, procedures, or guidelines exist for hiring, terminating, paying, or setting hourly rates for, casual employees.

Incompatible duties not segregated

No independent review

- Payroll-processing functions are not properly segregated. The Payroll and Benefits Administrator has unlimited access to the payroll system and performs all duties related to payroll processing. An administrative assistant is the only one who reviews payroll information, but this review is only a high-level reasonableness review, not a review of payroll details.

Lack of controls over manual cheques

- Between September 2006 and July 2007, the Payroll and Benefits Administrator created 83 manual cheques totalling $319,000 that were not processed by the contracted service provider. These payments were also not processed through the accounts-payable system and were therefore not subject to the controls in that system, such as segregation of duties between the approval of the expenditure and the creation of the payment. We found no evidence that the funds from these manual cheques were used for improper purposes.

Inadequate monitoring by department managers

- Monitoring of payroll expenses is inadequate. Department supervisors and managers, who are responsible for monitoring expenses charged to their budget codes, do not have access to payroll-expense information at an employee level. So they can't assess which employee's salary is charged to their budget code or if the salary paid is accurate.

Weaknesses resulted in several errors

As a result of the weaknesses in controls, we found several processing errors and transactions that lacked proper documentation, such as authorizations of rates, timesheets, and employment contracts and files.

Implications and risks if recommendation not implemented

The lack of sufficient and appropriate payroll controls creates the potential for fraud and errors to occur and go undetected. Employee information in the payroll system, including personal information, may be inaccurate and the College cannot rely on the completeness, integrity, or accuracy of its payroll system.

2. Grande Prairie Regional College

2.1 Financial reporting and year-end processes—recommendation repeated

Recommendation

We again recommend that Grande Prairie Regional College improve its processes and controls over financial reporting to increase efficiency in preparing accurate internal and external financial reports.

Background

Management must prepare accurate financial statements

Management is responsible for preparing financial statements and accompanying notes and schedules in accordance with Canadian generally accepted accounting principles. The Finance area is responsible for preparing the College and Foundation's financial statements. The Controller prepares financial statements for the Foundation, the College, and the consolidated financial statements.

Problems existed last year

In our *2006–2007 Annual Report* (No. 20—page 20), we recommended that the College improve its financial reporting processes as the College experienced significant difficulties and delays in preparing accurate financial statements promptly.

Criteria: the standards we used for our audit

The College should have effective processes and controls over preparing accurate financial statements and regularly reporting financial information to the College's senior management and Board.

Our audit findings

Still problems preparing financial statements

For the second year in a row, the College could not produce accurate financial statements within scheduled timelines. Draft financial statements were not available for audit when we began the final phase of our audit fieldwork on September 24, 2007. We did not receive the first balanced and complete set of financial statements until October 10, 2007—followed by several significant adjustments as a result of our audit work.

The Controller left the College early in August 2007 and the College contracted with a person to prepare the financial statements. Although we recognize this transition, the issues we experienced this year could have been alleviated with adequate financial processes, more regular monitoring and reviews throughout the year and processing information promptly.

Still missing summary financial information

Deans within the faculties continue to have access to the financial system to monitor actual expenditures against their budgets. The Vice President—Administration and the Controller monitors overall spending in the College. However, the Executive Committee still does not receive any quarterly summary financial information or reports throughout the year to monitor expenditures, identify possible cost overruns or surpluses, and reallocate or re-prioritize projects or spending.

Inadequate processes over contributions

In addition, the College does not have adequate processes over accounting for contributions. For example, the College received a grant of $330,000 restricted for research and initially recognized the full amount as revenue, even though it only spent approximately $50,000 on the project on the current year—thus overstating its revenues by $280,000 in the current year.

What is needed

To implement this recommendation, the College must:

- prepare regular financial statements and present them to the Executive Committee and Audit Committee.
- regularly review the general ledger accounts for variances and adjust account balances when any discrepancies are identified.
- prepare accurate year-end financial statements promptly.

Implications and risks if recommendation not implemented

Without effective and efficient processes that ensure timely and accurate reporting of the College's financial information at a reasonable cost, the Board and executive management may not have appropriate information to make decisions. And the College may spend too much time and money preparing financial information.

2.2 Capital asset management

Recommendation

We recommend that Grande Prairie Regional College improve its processes and controls over capital assets.

Background

College receives significant funding for capital assets

The College has a number of construction and renovation projects underway. It receives significant funding restricted for specific capital purposes. Once spent, this funding is recognized as revenue in the statement of revenue and expenses over the life of the related assets. The College also uses unrestricted funds to acquire capital assets.

Criteria: the standards we used for our audit

The College should have effective controls over capital assets. This includes maintaining a capital asset register and recording assets details, including their description, purchase date, location, tag number and funding source.

Our audit findings

Inadequate controls lead to significant errors

The College maintains a capital asset register for its capital assets, but it cannot effectively track the source of funding for capital assets or effectively review capital expenditures throughout the year. As a result, the College has trouble properly accounting for capital asset additions and contributions restricted to capital assets. This was one reason why it could not prepare accurate financial statements on time (see page 183). The College processed several adjustments at year end to correct transactions that incorrectly:

- recorded repairs and maintenance—totalling more than $300,000.
- calculated unamortized deferred capital contributions and amortization of deferred capital contributions—totalling more than $900,000.

Inadequate controls over sales of smaller capital assets

In addition, the College does not have adequate controls over disposal of capital assets. Although it budgets for large capital disposals and acquisitions, it does not have a centralized process to determine whether another College department may require them. Currently, each department decides to sell the assets in its area, and only informs the finance area via e-mail of assets disposed.

Implications and risks if recommendation not implemented

Lack of effective controls over capital-asset disposals could result in the sale of assets that other College departments may need, or inaccurate financial information that leads senior management to make inappropriate decisions.

3. Grant MacEwan College

3.1 Bookstore operations

Recommendation

We recommend that Grant MacEwan College improve its systems to:
- **manage and report inventories**
- **monitor and account for the use of petty cash**

Background

Bookstore operations

The College's bookstore sells books and other items to students, including transit passes and bus tickets.

College has several petty cash funds totalling $67,000

The College issues petty cash floats and petty cash funds to various departments for change (wherever there is a cash register), or to purchase small dollar items. The College's policy on petty cash funds states that funds will be issued in fixed amounts, up to $500. Petty cash custodians in the College hold $67,000 in petty cash funds or floats.

Criteria: the standards we used for our audit

The College should have effective and efficient processes over cash and inventory.

Our audit findings

Forensic investigation

Forensic accounting investigation underway

On September 17, 2007, management informed us of a forensic accounting investigation into management of the various stores. Certain staff members have been suspended with pay pending the outcome of this investigation. The investigation will determine the reason for the issues we note below on petty cash and bus passes.

Inventories

Manual processes inefficient and error prone

College staff told us that they cannot obtain appropriate management information on revenues, expenses and inventory levels from the bookstore system. Instead, they use manual spreadsheets to obtain the required information. This process is inefficient, and prone to error. As the College progresses its Financial Information Management Project (see page 187), it should improve this reporting process.

Quarterly forecasts for bookstore lacked detailed analysis

Although the bookstore's fourth quarter variance explanation compared the overall budget and actual revenues and expenses, there were inadequate explanations for large variances in different product types throughout the year. Bookstore and finance staff were unable to explain the large variances for different types of products the bookstore sells. For example, the College had difficulty tracking its stock of ETS transit passes and bus tickets and cannot account for $32,000 of ETS transit passes and bus tickets.

Petty cash

No regular spot checks of petty cash funds. Unexplained differences of $30,000

The Finance area relies on the petty cash fund/float acknowledgments that custodians complete and an independent person signs at year end. However, the Finance area does not do spot checks throughout the year to verify the petty cash. On September 17, 2007, management informed us that in September 2007, Finance staff conducted a cash-count at all locations after cashiers reported some missing cash from the safes. They found about $30,000 difference between the reported amounts and the actual cash. In addition, the College has not reviewed and updated its petty-cash policy, nor has it assessed whether the amounts assigned to each custodian are appropriate.

Implications and risks if recommendation not implemented

Inadequate processes and reviews increase the risk of fraud and error going undetected. In addition, manual processes are inefficient and prone to error.

3.2 Financial processes—implemented

Background

Better financial reporting processes this year

In our *2000–2001 Annual Report* (No. 39—page 216) we recommended that the College improve its financial reporting processes. In our *2006-2007 Annual Report Volume 2* (No. 19—page 18), we found that the College had made unsatisfactory progress implementing this recommendation because it had trouble producing accurate financial statements within the scheduled timelines. We outlined several ways the College could improve effectiveness and efficiency of the financial reporting process, such as improving the review and flow of reconciliations between opening and closing balances, improving the review of the working papers, and increasing automation for key processes.

Last year, we noted that the College had to complete balanced, accurate and reviewed financial statements, including supporting working papers, within scheduled timelines for the recommendation to be considered implemented.

Our audit findings

Automated financial statement preparation

The College implemented the recommendation by expanding the use of accounting and reporting software to produce the financial statements electronically. We received draft balanced and accurate financial statements and working papers at the agreed to deadline.

Consultant reviewed processes

The College hired a consultant to review its year-end processes and implemented a number of the consultant's recommendations. These included improving the referencing between accounts, enhancing supporting documentation, scanning for audit issues, and upgrading the process of mapping data to the financial statements.

College still working on other financial processes and controls

In previous years, we also highlighted several other areas where the College can improve the effectiveness and efficiency of its processes and controls. To do so, the College initiated a Financial Information Management Enhancement Project to cover broader financial processes, systems, and personnel. The College continues to resolve limitations of its financial reporting system. We will assess the impact of the project when we assess the adequacy, and test the operating effectiveness, of the College's various business processes and controls in future audits.

4. Systems—Lakeland College

4.1 Contract policies and procedures—implemented

Background

In our *November 2006 Report* (No. 6—page 30), we recommended that Lakeland College review and amend contract-management procedures to follow best practice, including:

- conducting background checks on companies that it does not know—before entering into contracts with them;
- updating its policy to require employees to disclose conflicts of interest;
- providing guidance on monitoring performance against contract terms; and
- retaining only the final signed version of contracts.

Our audit findings

Contract checklist created and followed

The College created a contract checklist that staff must complete before a new contract is signed. Among other things, the checklist includes an area that must be signed off by the contract initiator indicating that a background check has been done if necessary. This area was completed for each new contract in a sample we tested.

Other policies amended

The College amended its fraud and Code-of-Conduct policies to state that employees must avoid conflicts of interest and disclose any that exist.

Procedures also ensure timely contract signing

During training, the College told contracting departments that they need to prepare contract budgets and timelines before contracts are signed. To ensure this happens, this requirement is in the contract checklist. A sample of contracts we tested had both a budget and a timeline. And only the final signed version of the contract had been retained.

4.2 Monitoring performance—implemented

Background

In our *November 2006 Report* (No. 7—page 31), we recommended that Lakeland College improve supervision of its contracting staff. We also recommended that it monitor its contract performance against contract terms and the profitability of individual contracts in contracting departments.

Our audit findings

The Business Analyst ensures that the contract checklist has been completed for each new contract. In addition, all contracting departments prepare monthly reports to their supervisor disclosing actual contract performance versus budget, invoicing to date, and key milestones.

4.3 International students—implemented

Background

In our *November 2006 Report* (No. 8—page 34), we recommended that Lakeland College enforce its policy for involvement with international students.

Our audit findings

The new contract checklist requires that the Registrar be contacted if the contract involves international students. The Registrar signed the checklist for sampled contracts involving domestic and international students. Deans, directors and managers have been trained on the College's policy for involvement with international students during training on the new contracting process.

5. Portage College

Fuel purchases on fuel cards

Recommendation

We recommend that Portage College develop guidelines and procedures for review and approval of fuel purchases on fuel-purchase cards.

Background

Employees get fuel cards

Portage College issues fuel purchasing cards to designated employees for College use.

Criteria: the standards we used for our audit

The College should have guidelines and procedures to prevent misuse of fuel purchase cards. Expenditure officers should review and authorize fuel receipts before forwarding them for payment.

Our audit findings

No supporting documents or review of card use

The College does not have adequate review and approval processes over fuel card purchases. In a sample of six fuel purchase cards, none:

- had receipts to support the fuel purchases;
- were reviewed or approved by the appropriate expenditure officer before they were submitted for payment.

College uncovered unauthorized use of card

The College uncovered an unauthorized use of funds where, over 18 months, an employee charged $1,500 in gas purchases allegedly for personal use. These fuel purchases were not appropriately reviewed or approved before they were submitted for payment. The employee repaid the amounts and then left the College.

Implications and risks if recommendation not implemented

Without appropriate controls over review and approval of fuel purchase cards, fraud and error may go undetected.

6. Southern Alberta Institute of Technology

Construction management—implemented

Background

Signed contracts required before services start

In our *November 2006 Report* (No. 11—page 39), we recommended the Institute ensure signed contracts are in place for construction projects before services are supplied. Management accepted the recommendation and agreed to review the Institute's practices and make any changes needed in its contract-management processes.

Our audit findings

New processes implemented

The Institute has drafted an interim agreement template for construction projects where a construction manager is selected and a contract is being finalized. The draft template was reviewed by the Institute's lawyer. It outlines the responsibilities, services to be provided and the payment terms between the Institute and the construction manager. The Institute now requires signed contracts (interim or final) to be in place before services are received.

College and technical institute computer controls

1. Summary

Institutions rely on IT systems for secure, efficient services to students and staff

The 16 Public Colleges and Technical Institutes (Institutions) in Alberta rely more than ever on technology. From student information and scheduling systems to financial applications, Institutions collect, process, store, and manage a huge array of sensitive data on their information technology (IT) systems. Institutions rely extensively on these systems to efficiently and effectively deliver programs and services to students and staff, and to process their financial and student information. They also depend on the systems to process students' grades and to manage many critical internal controls. And, in highly automated environments, an IT control framework and effective general computer controls play an ever-increasing role in the overall internal control environment of each Institution.

Students and staff expect secure information

Students and staff expect Institutions to safeguard the confidentiality and accuracy of their personal information. Institutions must have efficient and effective controls to ensure that services and programs are not interrupted and student information is not susceptible to unauthorized access, misuse, or fraud. A well-designed IT control framework also helps the efficiency and effectiveness of each Institution's business processes and management oversight, enabling Institutions to provide efficient, reliable, and secure services to students and staff.

Department can guide Institutions on IT control frameworks

The Department of Advanced Education and Technology oversees public-sector Institutions in Alberta. We recommend that the Department—as the overall authority for Institutions—guide Institutions in using an IT control framework. That guidance will enable them to develop and implement well-designed, efficient, and effective IT controls.

Department responsible for quality of programs and services

But why include a recommendation to the Department in our report on Institution computer controls? The Department is not responsible to develop or implement IT control frameworks, control processes, or activities at Institutions. Nor does it ensure that Institutions have well-designed and effective IT controls. But as the overall authority, the Department is responsible for the quality of programs and services Institutions provide. It should know the issues and risks they face. Then it can give them guidance and leadership when needed on identifying risks and using an IT control framework to develop and implement IT controls to mitigate them.

Some Institutions need more help than others

Not all Institutions currently have the ability, resources, or knowledge to properly use an IT control framework to implement IT controls. The Department—as a centralized resource—is well-positioned to guide and help Institutions when requested/needed. It has knowledge and expertise to share.

Institutions must improve IT controls

The majority of Institutions do not have well-designed, efficient, and effective IT controls. All Institutions—some more than others—need to better identify risks and implement well-designed and effective IT controls to mitigate them. Without well-designed and effective IT controls, student, financial, and Institutions' data, programs, and services are at risk.

2. Audit objectives, scope and timing

Objectives

Does Department give adequate guidance?

Does the Department provide adequate guidance to Institutions on using an IT control framework to develop and implement well-designed, efficient and cost-effective IT controls?

Do proper IT controls exist?

Does each Institution have a set of well-designed, efficient, and effective IT control processes and activities—developed by using an IT control framework?

Are IT controls well-designed and effective?

Were IT control processes and activities implemented and operating effectively at each Institution throughout the period under review to mitigate risks to their information technology systems, and to provide secure services and programs to students and staff when needed?

Scope and timing

New and previous recommendations from financial-statement audits

As part of the June 30, 2007 financial-statement audits of Colleges and Technical Institutes in Alberta, we tested general computer controls, followed up on previous recommendations, and made new recommendations. We communicated our findings on the status of previous recommendations and our new recommendations in letters to management of each Institution. Our recommendations are in Appendix A—Post-secondary institution recommendations on page 203.

Why we tested computer controls

We tested the general computer controls to determine if:

a. each Institution has a well-designed, efficient, and effective IT control framework.
b. each Institution's IT control processes and activities were well designed to mitigate identified risks to the Institution and to provide secure services and programs to students and staff when needed.
c. the IT control processes and activities were operating effectively throughout the period under review.

Table summarizes findings and recommendations

A summary of our findings for all IT controls tested in March-August 2007 can be found in the table on page 198.

3. Conclusion

The Department does not provide guidance, but it has policies on IT governance and control frameworks

The Department does not provide guidance to Institutions on IT control frameworks and controls. The Department has developed high-level IT governance and IT control framework policies. And it works with Institutions through the Alberta Association for Higher Education in Information Technology (AAHEIT) as an "ex-officio" member. But the Department does not have a formal or informal process to share its knowledge of IT governance, control frameworks, or how to efficiently implement well-designed IT control processes and activities.

No Institution has comprehensive or well-designed control processes

Larger Institutions typically do better

No Institution has a comprehensive set of well-designed, efficient, and effective IT control processes and activities to mitigate risks and provide services and programs as securely and efficiently as possible. There are significant differences in the maturity, efficiency, and effectiveness of IT controls among Institutions. Larger Institutions generally have more effective IT controls while smaller Institutions more typically have only informal, inefficient, and ineffective IT controls.

Compensating controls not enough

Some Institutions have implemented other controls or processes to compensate for the absence of well-designed and efficient IT controls, but these were often ineffective and inefficient.

All Institutions need better controls

Institutions need to better identify and assess their risks and then implement well-designed, efficient, and effective IT controls to mitigate the risks and provide secure services and programs when needed to all students and staff.

Three larger Institutions have better controls

Three of the four larger Institutions—Grant MacEwan, Mount Royal, and the Northern Alberta Institute of Technology (NAIT)—have better IT controls to mitigate most risks and generally provide efficient services. However, all three Institutions can make improvements. The IT controls at the fourth one, Southern Alberta Institute of Technology (SAIT), are not as good. SAIT has a plan to resolve its IT control issues and to better mitigate risks to its computing environment.

Smaller Institutions have trouble getting good IT controls

Smaller Institutions, such as Alberta College of Art and Design (ACAD), Olds, and Northern Lakes, do not have the same resources as the larger Institutions. They are challenged to implement and maintain adequate IT controls.

We regularly conduct IT audits at Bow Valley, Grande Prairie, Lakeland, Medicine Hat, Norquest, Northern Lakes, Olds, and Portage Colleges. All these Institutions need additional work—some more than others—to implement well-designed and efficient IT controls. Of these Institutions, Norquest and Lakeland Colleges have made significant progress implementing previous recommendations.

Three other colleges, ACAD, Keyano, and Red Deer, had not previously had a comparable IT audit. We did such an audit this year and found that only Keyano College had adequate IT controls, needing less improvement than the others.

Four Institutions with least effective controls

ACAD, Grande Prairie Regional College, Northern Lakes College, and Olds College have the least effective IT controls and the greatest need to resolve control problems. They did not have effective IT control processes or activities. Nor did they have plans to identify risks to their financial and student information or to implement well-designed and effective IT control processes to remediate risks and provide secure services and programs when needed.

All Institutions need additional IT control work

All Institutions need to do additional work to have well-designed and effective IT controls. Smaller Institutions—especially the four Institutions referred to above—need significantly more work. They would benefit greatly from guidance from the Department on using an IT control framework to implement well-designed, efficient, and effective IT controls.

4. Recommendation

Well-designed and effective IT control policies and processes

Recommendation No. 8

We recommend that the Department of Advanced Education and Technology give guidance to public post-secondary Institutions on using an IT control framework to develop control processes that are well-designed, efficient, and effective.

Background

IT control frameworks give assurance

Well-designed and effective IT control processes are the best way to preserve the security and integrity of an Institution's information and systems. A comprehensive IT control framework should be a critical part of every organization's internal control program to mitigate risks and:

- provide secure services to students and staff.
- protect the confidentiality and security of information.
- ensure that systems are available when needed.

IT control framework a means to attain sufficient and effective controls

An IT control framework should drive the IT control processes and specific activities designed to achieve identified control objectives, business objectives, and to mitigate identified risks. Effective management practices also monitor and measure the effectiveness of the IT control framework to ensure that IT controls operate as designed and provide efficient and secure services to all students and staff. If the security or integrity of these IT systems is compromised, they can immediately impair the accuracy of the Institution's student and financial information and cause extra work and additional costs in providing services to students and Institution staff.

COBIT a recognized international standard

An IT control framework, such as *Control Objectives for Information and related Technology* (COBIT)[1], is a key element in developing—and ensuring that there are—proper controls over an organization's information and the systems and processes that create, store, manipulate, and retrieve important data. COBIT is an industry-recognized best practice IT control framework developed and maintained by the Information Technology Governance Institute. COBIT has 34 high-level objectives and 211 individual control activities. It gives senior management and IT users generally accepted measures, indicators, processes, and best practices to maximize IT benefits and minimize risks. Further information on an IT control framework can be found on page 171 in this report.

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[1] COBIT 4.1. ©1996-2007 IT Governance Institute. All rights reserved. www.itgi.org

Audit based on COBIT with 6 high-level areas

Our general computer control testing framework is based on a subset of COBIT and has 25 high-level objectives and 66 detailed control activities that we assess, in the following 6 high-level areas:

- Strategic, IT Control Framework, and Risk Management
- Computer Operations and Security Controls
- Logical Access to Programs and Data
- Program Development and Program Change
- IT Continuity Physical and Environmental Security
- Outsourced Service Provider Management

Criteria: the standards we used for our audit

The Department should provide guidance to Institutions on using an IT control framework to develop and implement well-designed, efficient, and effective IT controls to mitigate identified risks.

Institutions should:

- use an IT control framework to develop and implement well-designed, efficient, and effective IT control processes.
- have well-designed, efficient, and effective IT control processes to mitigate risks and provide secure services and programs to students and staff when needed.

Our audit findings

Institutions would benefit from better guidance from Department on IT governance

The Department works with all publicly funded Institutions, through AAHEIT as an ex-officio member. The Department has developed an IT governance framework and a set of high-level IT policies and has offered to share this work through AAHEIT. The Department does not have a formal process to give Institutions guidance on using their IT governance framework to develop and implement well-designed and effective IT control processes.

Institutions need to assess risks and implement IT controls

In our letters to management, we made specific recommendations to Institutions on improving their controls. These recommendations are in Appendix A—Post-secondary institution recommendations. The Institutions agreed with all the recommendations. Management of each Institution needs to assess the recommendations—the risks associated with them and the costs of mitigating the risks—and then decide on the level of IT controls appropriate for their Institution.

The methodology used to audit IT controls at Lethbridge College was not comparable to that used at other Colleges. So Lethbridge College is not in the table below. Lethbridge College's IT controls will be audited with the same methodology as all other Institutions in the 2008 audit year.

Our computer control testing methodology is represented by the 6 high-level areas in the table below. Appendix B—College and technical institute computer controls audit criteria has a general description of each area, what we look for, and why.

The following table summarizes both new and previous unresolved findings and recommendations, reported directly to each Institution's management, in the 6 high-level areas. It does not show previous recommendations that are implemented.

Three types of recommendations in table

New	△	New recommendation for June 2007 audit
Satisfactory progress	●	Previous recommendation with satisfactory progress
Repeated	⬢	Previous recommendation with unsatisfactory progress

Summary of findings for all IT controls tested in March-August 2007

General computer control section**	Institution	Strategic controls, IT control framework, and risk management	Computer operations and security controls	Logical access to programs and data	Program development and program change	IT continuity physical and environmental security	Outsourced service provider controls
Four Colleges with ineffective IT controls. Significant IT control work is required immediately.	ACAD	△	⬢	△	△	⬢	△
	Grande Prairie	⬢	⬢	⬢	⬢	⬢	Not Applicable
	Northern Lakes	△	△	△	△	△	△
	Olds	⬢	⬢	⬢	⬢	⬢	Not Applicable
Institutions that need additional work to have good IT controls	Bow Valley	△	No Significant Findings	⬢	●	No Significant Findings	Not Applicable
	Keyano	No Significant Findings	No Significant Findings	No Significant Findings	△	●	△
	Lakeland	△	●	●	●	No Significant Findings	Not Applicable
	Medicine Hat	Not Assessed	●	●	⬢	●	⬢
	Norquest	△	●	⬢	No Significant Findings	●	Not Applicable
	Portage	△	△	△	●	●	Not Applicable
	Red Deer	△	△	△	△	△	Not Assessed
	SAIT	⬢	No Significant Findings	No Significant Findings	●	⬢	Not Applicable
Three Institutions with good IT controls.	Grant MacEwan	●	●	△	No Significant Findings	●	Not Applicable
	Mount Royal	●	●	●	△*	●	Not Applicable
	NAIT	Not Assessed	●	No Significant Findings	No Significant Findings	●	Not Applicable

* The current issue at Mount Royal College was identified in the Bookstore with sales and financial systems separate from the College's main computing environment. Mount Royal has made satisfactory progress on previous recommendations throughout the rest of its computing environment.

** For more information about each of the high–level IT control areas please refer to Appendix B: College and technical institute computer controls audit criteria.

Three notes in the table

Not applicable	This area does not apply to this Institution.
Not assessed	No detailed testing of this area at this Institution—to assess in more detail next audit.
No significant findings	Testing did not identify significant findings.

Implications and risks if recommendation not implemented

Without a well-designed process to identify risks to their computing environment, Institutions cannot be aware of all risks to their information systems and data that IT controls can mitigate. Institutions with better IT controls are better able to identify risks and mitigate them. Institutions with poor IT controls cannot efficiently or effectively manage or mitigate risks to their systems and data. These Institutions thus cannot rely on their student and financial data, applications, or systems to provide complete, accurate and valid information or services and programs to students and staff when needed. Nor can they efficiently meet their business goals and objectives.

Institutions:
- cannot know or control risks
- cannot rely on student or financial data
- may suffer waste and fraud and miss their goals

Inadequate and ineffective IT control processes and activities can lead to:
- poorly planned or defined projects—wasted resources due to lack of project prioritization, duplicate or redundant tasks or projects, discontinued projects, implementation of systems or applications that do not work as expected or do not provide the expected benefits to the Institution.
- student personal data being lost, improperly accessed, misused or disclosed.
- Institution systems and applications being hacked or abused by malicious users.
- economic or reputational cost of down time and disaster recovery events—as services the Institution's students and staff rely on are unavailable when needed.

Appendix A—Post-secondary institution recommendations

Appendix A—Post-secondary institution recommendations

Introduction

In our letters to Institutions' management, we make specific recommendations to Institutions on improving their IT control processes and activities. Recommendations from the 2006–2007 financial year are detailed below. We used these to determine what areas of the chart on page 198 of the *April 2008 Auditor General Report* each Institution had recommendations in.

There are three types of recommendations. New, Satisfactory progress, and Repeated.

New	New recommendations were first identified and reported to the Institution as a part of our June 2007 year-end audit.
Satisfactory progress	A satisfactory progress recommendation: • was made to the Institution within the past three years. • is currently being implemented by the Institution. Satisfactory progress means the Institution can show that it has developed and is following an appropriate plan to fully implement the recommendation within three years.
Repeated	A repeated recommendation either: • was made more than three years ago and is not fully implemented, • is not being actively implemented by the Institution, or • does not have an appropriate plan to ensure that it is implemented within three years.

College	Recommendations made to management
Alberta College of Art and Design	**New** We recommend that the Alberta College of Art and Design complete a risk assessment that identifies significant business and operational risks and implement appropriate controls to mitigate the risks identified. We recommend that the Alberta College of Art and Design document and follow a comprehensive access administration policy and control processes. We also recommend that the College obtain assurance from the Southern Alberta Institute of Technology (SAIT) that appropriate access controls are in place for the student information system that SAIT hosts and administers for the College. We recommend that the Alberta College of Art and Design provide information system access privileges for each employee based on job function and segregate the access functions so that no one individual can initiate and process a transaction. We recommend that the Alberta College of Art and Design: • follow its purchasing policy when it selects outsourced service providers and ensure there is a contract with the outsourced service provider that clearly defines the terms and conditions, including security and confidentially requirements. • document and follow control processes to ensure that outsourced service providers' access to systems is secure, and that all changes to information systems and data made by service providers are appropriate and authorized. • document and implement a comprehensive information technology (IT) security policy. We recommend that the Alberta College of Art and Design document and implement a comprehensive information technology (IT) security policy. We also recommend that the College complete an IT risk assessment and implement appropriate IT controls to mitigate identified risks. We recommend that the Alberta College of Art and Design design and implement a comprehensive change-management policy and effective control processes. We further recommend that the College obtain assurance from the Southern Alberta Institute of Technology (SAIT) that changes to the Banner application affecting the College's student information follow an appropriate change-management process. **Repeated** We again recommend that the Alberta College of Art and Design strengthen internal controls for computer system access and server backups. We also again recommend that the College implement a computer use policy.

College	Recommendation
Grande Prairie Regional College	**Repeated** We again recommend that the College develop policies and implement processes and controls over its general computer environment to maintain the confidentiality and integrity of its systems and the information it contains. We recommended that the College develop a disaster recovery plan (DRP).
Northern Lakes College	**New** We recommend that Northern Lakes College: • do a comprehensive information technology (IT) risk assessment to identify and rank the risks it can mitigate with properly designed and effective IT controls and what risks can be accepted; and • document and follow appropriate IT controls to mitigate the risks it identifies. We recommend that Northern Lakes College complete and test an information technology (IT) resumption plan.
Olds College	**Repeated** We again recommend that Olds College improve documentation and procedures to strengthen its computer control environment.
Bow Valley College	**New** We recommend that Bow Valley College: • complete a comprehensive information technology (IT) risk assessment to identify and rank the risks it can mitigate with properly designed and effective IT controls. • document and follow appropriate IT controls to mitigate the risks it identifies. • document risks that cannot be effectively or efficiently mitigated and a process to accept these risks. **Repeated** We again recommend that the College ensure computer system access privileges are appropriate and promptly removed for terminated employees. **Satisfactory progress** We recommended the College improve system access controls for IT staff, an employee in the Finance department and an employee in the Registrar's office. We recommended that the College develop a long-term plan that includes objectives, goals, and strategies for information technology. We recommended that the College: • document change-management procedures. • define the documentation requirements for showing compliance with change-management procedures.

College	Recommendation
Keyano College	**New** We recommend that Keyano College improve controls over changes made to its information systems. We recommend that Keyano College implement appropriate physical and environmental controls for the data server rooms housing business, financial and critical information assets in the enterprise. **Satisfactory progress** We recommended that Keyano College develop and regularly test and update an information technology disaster recovery plan.
Lakeland College	**New** We recommend that Lakeland College: • complete a comprehensive information technology risk assessment to identify and rank the risks it can mitigate with properly designed and effective IT controls. • document and follow appropriate IT controls to mitigate the risks it identifies. **Satisfactory progress** We recommended that Lakeland College implement appropriate security policies and control processes to protect its financial, student, and other important information.
Medicine Hat College	**Repeated** We again recommend that Medicine Hat College ensure that there are adequate controls over its outsourced service providers. **Satisfactory progress** We recommended that Medicine Hat College ensure controls are adequate to protect the information that it stores in its computer systems and sends through computer networks. We recommended the College ensure it has adequate environmental controls and recovery procedures to continue providing IT services in case of a disruption.
Norquest College	**New** We recommend that NorQuest College implement an IT control framework to mitigate identified risks. **Repeated** We again repeat our recommendation that NorQuest College communicate security policies and improve controls over access to financial and student information. **Satisfactory progress** We recommended that the College document and test an information technology (IT) continuity plan for its important business processes and its financial and student information systems. We recommended that the College document procedures for monitoring its computing environment and responding to incidents and problems.

College	Recommendation
Portage College	**New** We recommend that Portage College: • complete a comprehensive information technology (IT) risk assessment to identify and assess risks of collecting, processing and storing information. • mitigate identified risks with properly designed and effective IT controls. • regularly assess the operating effectiveness of IT controls. **Satisfactory progress** We recommended that the College develop a business-resumption plan (BRP) to ensure that it can resume services in a reasonable time after a disaster. We recommended the College improve controls over changes in its IT environment.
Red Deer College	**New** We recommend that Red Deer College improve its general computer environment controls by: • performing annual risk assessments and implementing information technology controls to mitigate risks identified; • implementing appropriate security over information and information technology assets; • managing changes to computer programs; • completing and testing its disaster recovery plan.
Southern Alberta Institute of Technology	**Repeated** We again recommend that the Southern Alberta Institute of Technology's information technology (IT) department develop and enter into service level agreements with the other Institute departments that it provides IT services to. We again recommend that the Southern Alberta Institute of Technology: • conduct an IT risk assessment of the Institute's computing environment and align these risks with the Institute's overall business goals and objectives, • include in the risk assessment, risks to the confidentiality and integrity of information, as well as availability, and • identify and document IT control activities to mitigate identified risks. We again recommend the Southern Alberta Institute of Technology develop and regularly test and update an IT disaster recovery plan.
Grant MacEwan College	**New** We recommend that Grant MacEwan College document and follow a comprehensive access-administration policy and supporting control processes. **Satisfactory progress** We recommended that the College develop and implement well-designed control processes to improve their computer control environment for: • Change control; • Continuous service; • System security; and • Risk assessment.

College	Recommendation
Mount Royal College	**New** We recommend that Mount Royal College ensure that appropriate controls and sufficient documentation exist for change-management processes for the College's Bookstore system. **Satisfactory progress** We recommended that Mount Royal College review the results of the general computer environment control audit, assess the findings, and implement a plan to resolve weaknesses and apply appropriate information technology (IT) control processes.
Northern Alberta Institute of Technology	**Satisfactory progress** We recommended that the Institute assign responsibilities to monitor compliance with security policies and procedures. We recommended that the Institute update its Business Continuity Plan (BCP) based on a risk assessment, and develop and implement a Disaster Recovery Plan (DRP) that supports the BCP. We recommended that the Institute develop documented change-management procedures, document all changes made to its computer systems, and require written user acceptance testing signoffs. We recommended that the Institute develop a formal strategic plan for information technology, including performance measure targets.

Appendix B—College and technical institute computer controls audit criteria

Appendix B—College and technical institute computer controls audit criteria

1. **Strategic controls, IT control framework, and risk management**—Institutions should implement good management processes and strategic controls to identify risks and efficient and effective controls to mitigate them.

   Controls in this section are sometimes called "entity-level controls" as we look for controls that Institutions should implement with their IT group. These controls ensure that IT management systems and processes match and support each Institution's goals and objectives. Often, the Institution sets the tone for these controls and each IT group ensures they are followed.

   Does each Institution have:

   Effective IT management processes?

   - an effective IT steering committee or other form of IT oversight?
   - an effective process to ensure that IT goals and objectives match and support its goals and objectives?
   - appropriate IT policies, procedures, and standards?
   - an effective process that ensures it has the right resources and that IT personnel understand their roles in security and internal controls?
   - a process to identify risks and implement well-designed and effective IT controls to mitigate them?

2. **Computer operations and security**—Institutions should have appropriate IT security standards and processes to monitor and remediate security incidents. Computer operations and security controls ensure that Institutions can mitigate external and internal vulnerabilities and security risks.

   Do Institutions have well-designed and effective control processes and standards for:

   Is student and financial data protected?

   - protecting the network against outside attacks.
   - monitoring for and protecting against unauthorized access to student and financial systems and data.
   - promoting security awareness among staff and students.
   - protecting against viruses and malicious software.
   - monitoring for and identifying security incidents.
   - resolving problems and security incidents.
   - identifying and resolving security vulnerabilities in the computing environment.

3. **Logical access to programs and data**—Institutions should have well designed processes to request, approve, grant, review and promptly terminate access to their network and important systems and applications.

User access controls ensure that:

- only approved and appropriate people can access Institution and student data.
- users of Institution systems and data get only the minimum access they need for their job.
- the risk of unauthorized people accessing, using, changing, deleting, or abusing student and Institution systems and data is reduced and managed.

Is user access correct?

Do Institutions have well-designed and effective control processes that are properly documented and communicated, to ensure that:

- all user access to student, financial and supporting infrastructure is properly requested and approved.
- users do not have more access than their job requires.
- all user access is regularly reviewed to ensure that each user is still valid and their access is still appropriate.
- all transactions can be traced to an individual user.
- there is appropriate segregation of duties in requesting, approving, and granting access to systems and data.
- no one user has excessive access letting them bypass critical control processes like initiating and approving a purchase order.
- authentication controls, like passwords, meet or exceed accepted best practices.
- access is promptly terminated when people leave or change jobs.

4. **Program development and program change**—Institutions should have well designed and effective processes to request, approve, develop, and test changes to systems and applications and to move them into the production environment in a controlled manner.

Program-development methodologies ensure that the right application or system is implemented—on time, on budget, and meeting user needs. Change-management controls ensure that all changes or upgrades to existing systems and applications are properly implemented. Both control processes ensure that Institution systems, applications, and data work as expected, and that student and financial data and programs and services are not impaired.

Do Institutions have well-designed and effective control processes to ensure that:

Are changes approved and tested?

- all new systems and applications have appropriate business cases and approvals before they are purchased or developed?
- changes to existing systems are properly requested?
- changes to existing systems are tested before they are implemented?
- changes are approved before being implemented?
- major changes or new systems and applications are reviewed after implementation to ensure they meet user needs and follow proper control processes?

5. **IT continuity, physical and environmental security**—Institutions should have well-designed and effective processes and standards to ensure that data is physically and environmentally secure and can be restored when needed.

Effective IT continuity control processes ensure that important systems and data have proper back up and retention polices. And they ensure that important systems can be restored within agreed on times in an emergency.

Physical and environmental security controls ensure that Institution physical assets are protected against theft, fire, and other disasters.

Do Institutions have well-designed and effective control processes to ensure that:

Can data be restored when needed?

- backup and retention policies and times are documented and agreed to by the IT group and the users of the systems and data?
- there are regular tests of back media, systems, and resources to ensure that systems and data can be restored in the agreed-on times and when needed?
- there are adequate facilities to recover needed systems and data in case of an emergency?
- the IT continuity plan supports the Institution's overall business continuity plan?

Do Institutions have well-designed physical and environmental security control processes to ensure that:

Is physical and environmental security good?

- physical and environmental standards are defined, agreed to and consistently met?
- only properly authorized people have physical access to systems and data?
- physical access to systems and data is monitored?
- fire detection and suppression are adequate?
- temperature and humidity control systems are adequate?

Are outsourced service providers monitored?

6. **Outsourced service-provider management**—Institutions should have well designed control processes to enter into contracts with outsourced service providers. Institutions must also have well-designed controls to ensure that outsourced service providers consistently meet all contractual obligations and that Institution systems and data remain secure.

Do Institutions use outsourced service providers that have, or could have, physical or administrative access to Institution systems or data? If so, do Institutions have well-designed and effective controls to ensure that:

Is student and financial data safe with, and from, service providers?

- outsourced service providers can provide the services they promise?
- appropriate contracts are in place, with defined and agreed-to service levels?
- controls are in place to monitor and review service providers' actions?
- controls are in place to ensure the security, confidentiality, and integrity of all student and financial data?
- a process is in place to identify problems with outsourced service providers and to escalate the problems if not resolved promptly?

Education

This chapter includes our annual review of school jurisdiction audited financial statements and management letters, and our financial statement audit of Northlands School Division for the year ended August 31, 2007, which we completed since our October 2007 report. Our October 2008 report will include the results of March 31, 2008 year-end financial statement audits that we complete up to August 2008.

Summary: what we found in our audits

Other entities that report to the Minister

- Northland School Division No. 61

  We issued an unqualified opinion on the financial statements of Northland School Division No. 61.

- School jurisdiction financial reporting and audit findings

  We have summarized financial statement reporting issues and internal control weaknesses from our review of the audited financial statements and audit findings for the 74 school boards and charter schools.

Scope: what we did in our audits

We performed the following work on entities that report to the Minister:

- We audited the financial statements of the Northland School Division No. 61 for the year ended August 31, 2007.
- We reviewed the audited financial statements and audit findings for the 74 school jurisdictions and charter schools for the year ended August 31, 2007. We did this work because the *Auditor General Act*, in Section 19(4), requires us to report to the Legislative Assembly on the results of the examinations of school jurisdictions.

Our audit findings and recommendations

1. Review of school jurisdiction audited financial statements and management letters

Background

We audit one of the school jurisdictions (Northland). For those jurisdictions we don't audit, we review the management letters sent to the jurisdictions by their auditors. Those audits were not designed to assess all key systems of control and accountability. However, the auditors do report to management about weaknesses that come to their attention when auditing the financial statements. We also review the auditors' report on the financial statements.

There are 74 school jurisdictions comprising 62 school boards and 12 charter schools. This is one less than in the prior year because one charter school closed during the year.

Our audit findings

One qualified audit opinion

Auditors' Reports—of the 74 school jurisdictions, one (not that same one reported in 2006) received a qualified auditors' report for the year ended August 31, 2007. The report was qualified because the auditor was unable to verify the completeness of revenue from gifts and donations. The Department is working with the school jurisdiction to have this qualification removed.

All school jurisdiction auditors reported that the 2007 financial statements were prepared in accordance with Canadian generally accepted accounting principals (GAAP). Last year one auditor reported that the 2006 financial statements were prepared on a disclosed basis of accounting.

Financial statements—of the 74 school jurisdictions, 6 (11 in 2006) school boards and 2 (1 in 2006) charter schools incurred annual operating deficits. Annual operating deficits are acceptable to the Department as long as sufficient accumulated operating surplus funds are available to cover the shortfall. Each of these jurisdictions had sufficient accumulated surpluses to cover the annual operating deficits.

One accumulated operating deficit

Accumulated operating deficits are not acceptable to the Department. School jurisdictions with accumulated operating deficits are expected to work with the Department to eliminate the accumulated operating deficit in accordance with a Minister approved deficit elimination plan. Of the 74 school jurisdictions, one reported an accumulated operating deficit at August 31, 2007 ($718,000—Holy Spirit Roman Catholic Separate Regional Division in Southern Alberta). Of the 3 jurisdictions that had accumulated operating deficits at August 31, 2006, 2 have eliminated those deficits.

Areas for improvement

Management letters—the following is a summary of the audit findings and recommendations reported to 74 school jurisdictions by their auditors for the year ended August 31, 2007. We have grouped our summary into the following categories:

- Financial reporting and governance
- Internal control weaknesses, and
- Information technology management

Financial reporting and governance

a) **Policies and procedures**—18 jurisdictions (including 5 of the 13 reported in 2006) need to update or implement formal procedures and policies.

b) **Review of financial information**—16 jurisdictions (including 5 of the 15 reported in 2006) need to improve their review of financial information such as bank reconciliations, journal entries, monthly financial statements and variances between budget and actual expenditures.

c) **Accounting issues**—9 jurisdictions (including 2 of the 4 reported in 2006) need to resolve accounting issues relating to non-monetary transactions, proper recording, reviewing and reconciling journal entries, recording revenue at a gross amount and recording accruals for capital grants.

d) **Timeliness of financial recording**—8 jurisdictions (including 4 of the 6 reported in 2006) need to ensure accounting transactions, accruals, receivable statements or financial statements are prepared or recorded on a regular and timely basis.

e) **Board approval**—4 jurisdictions (none of the 6 reported in 2006) need to ensure that board approvals are obtained for matters such as the amount of net assets to restrict, plans to spend excess school generated funds, board minutes and superintendent expenses.

f) **Budgetary process**—2 jurisdictions (neither of the 2 reported in 2006) need to improve their budgetary processes.

g) **Audit committee**—no school jurisdictions (1 reported in 2006) reported as needing to establish an audit committee.

Internal control weaknesses

a) **Payroll**—18 jurisdictions (including 3 of the 10 reported in 2006) need to improve controls over the accuracy of and access to payroll information.

b) **Cash management**—17 jurisdictions (including 9 of the 19 reported in 2006) need to improve cash management processes and controls.

c) **Purchases**—12 jurisdictions (including 6 of the 21 reported in 2006) need to improve controls over the purchase cycle such as the review and authorization processes over purchases and payments, employee sign off for goods received and retention of supporting documentation.

d) **School-generated funds**—9 school jurisdictions (including 7 of the 26 reported in 2006) need to improve the processes used to collect, record, spend and report school-generated funds.

e) **Capital assets**—7 jurisdictions (including 2 of the 5 reported in 2006) need to improve the recording and tracking of capital assets.

f) **Segregation of duties**—7 jurisdictions (including 2 of the 6 reported in 2006) need to have segregation of duties over the authorization and recording of transactions or the custody of and accounting for certain assets.

g) **Goods and Services Tax**—3 jurisdictions (none of the 5 reported in 2006) need to review their processes for recording GST and remitting GST returns.

h) **Personnel management**—no jurisdictions (6 reported in 2006) need to take action to deal with personnel management issues.

Information technology management

a) **Computer security**—10 jurisdictions (including 5 of the 8 reported in 2006) need to improve computer security processes by having unique individual usernames and passwords, implementing a mandatory password change policy, backing up data at an offsite location and developing a Business Continuity Plan and a Disaster Recovery Plan.

The Department contacts all jurisdictions and encourages them to deal with the issues raised in the management letters, particularly noting recommendations repeated from prior years.

Past recommendations

Outstanding recommendations

This is a complete listing of numbered and unnumbered recommendations that are not yet implemented.

Auditee	Original Report Year	Original Rec.	Repeated	Recommendation subject
Cross-Ministry				
Executive Council	2004–05	1 & 2		Recruiting, evaluating and training boards of directors
Service Alberta	2005–06	22		IT Project Management
Treasury Board	2002–03	p. 27		Consistency of performance measures in government and ministry business plans
Treasury Board	2006–07	17		Government credit cards
Aboriginal Relations				
	Nov. 2006	N.4		Role of Métis Settlements Ombudsman
	2006–07	Vol. 2, p 124		Grant monitoring
Advanced Education and Technology				
	2005–06	23		Effective monitoring of employers providing apprenticeship training
	2005–06	Vol. 2, p. 12		Apprenticeship program—selecting which employers to visit based on risk and opportunity
Alberta College of Art and Design	2006–07	Vol. 2, p. 21		IT internal controls
Grande Prairie Regional College	2006–07	20		Financial processes
Grant MacEwan College	2004–05	p. 104		Computer control environment
Grant MacEwan College	Nov. 2006	N.9		Post Secondary Institutions: Grant MacEwan College construction management
Grant MacEwan College	Nov. 2006	N.10		Post Secondary Institutions: Donations to Grant MacEwan College
Mount Royal College	2004–05	p. 100		Retention and severance agreements
Mount Royal College	2004–05	p. 101		Governance and Human Resources Committee Charter
University of Alberta	1999–00	35	2000–01: 37 2001–02: 40 2002–03: 34	Internal control systems
University of Alberta	2003–04	p. 252		Strategic planning for Research
University of Alberta	2005–06	Vol. 2, p. 29		Campus security services
University of Alberta	2006–07	Vol. 2, p. 24		Security configuration settings
University of Calgary	2003–04	26		Planning for research capacity
University of Calgary	2003–04	p. 254		Research measures and targets
University of Calgary	2003–04	p. 257	2006–07: Vol. 2, p. 15	Controls over sponsored research and trust accounts

Auditee	Original Report Year	Original Rec.	Repeated	Recommendation subject
University of Calgary	2004–05	18		Research roles and responsibilities
University of Calgary	2004–05	p. 91		Research policies
University of Calgary	2004–05	p. 92		Research project proposals
University of Calgary	2004–05	p. 93		Research project management
University of Calgary	2004–05	p. 94		Accounting for research revenues and expenditures
University of Calgary	2005–06	Vol. 2, p. 20		General computer control
University of Calgary	2005–06	Vol. 2, p. 24	2006–07: Vol. 2, p. 13	PeopleSoft security
University of Calgary	2005–06	Vol. 2, p. 26		Campus security services
University of Calgary	2006–07	18		Information technology (IT) governance and control framework
University of Calgary	2006–07	Vol. 2, p. 12		Controls over payroll
University of Lethbridge	2006–07	21		IT internal framework
Agriculture and Rural Development				
	2000–01	3	2004–05: 20	Evaluating program success: grant management
	2002–03	3		Performance measurement
	2003–04	3		BSE Report July 2004: Risk assessment for the agriculture and agri-food industry in Alberta
	2005–06	Vol. 2, p. 39		Verifying eligibility for the Canada-Alberta Fed Cattle Set Aside program
	2005–06	Vol. 2, p. 40		Developing and monitoring compliance with an information technology security policy
	2005–06	24		Verifying eligibility for Farm Fuel Benefit program
	Nov. 2006	N.12		Expense Accounts: Processes for reporting and dealing with allegations of employee misconduct
Agriculture Financial Services Corporation	2005–06	Vol. 2, p. 43		Information technology security
Agriculture Financial Services Corporation	2006–07	Vol. 2, p. 32		Loan loss allowance methodology and process
Agriculture Financial Services Corporation	2006–07	Vol. 2, p. 34		Wireless technology
Agriculture Financial Services Corporation	2006–07	Vol. 2, p. 35		Manual CAIS claims
Also see Recommendations to more than one ministry—page 230				

Auditee	Original Report Year	Original Rec.	Repeated	Recommendation subject
Children and Youth Services				
	1999–00	9	2000–01: 5	Cost and results of information
	2001–02	7	2002–03: 7 2004–05: 25	First Nation expense recoveries
	2001–02	8	2002–03: 69	Contract Management Systems
	2001–02	9		Risk assessment and internal audit services
	2002–03	6	2004–05: 25	First Nation Agency accountability
	2003–04	7		Reporting to senior management on the Delegated First Nation Agencies
	2006–07	6		Child intervention services: Enhanced child intervention standards
	2006–07	7		Child intervention services: Accreditation systems for service providers
	2006–07	8		Child intervention services: Department compliance monitoring
	2006–07	p. 86		Child intervention services: Authorities compliance monitoring processes
	2006–07	p. 88		Child intervention services: Authorities monitoring of service providers
Education				
	1998–99	22	2001–02: 36	Risk management
	2004–05	27	2006–07: 22	(Purchase of textbooks) Savings generated by Learning Resources Centre
	2005–06	25		School board budget process
	2005–06	26		School board interim reporting—minimum standards and best practices
	2006–07	Vol. 2, p. 45		Business cases
Employment and Immigration				
	2006–07	Vol. 2, p. 55		Income support program—exception reports
	2006–07	Vol. 2, p. 56		Compliance audit function—Income support program
	2006–07	Vol. 2, p. 57		Debit cards
	2006–07	Vol. 2, p. 58		Capital asset policy
	2006–07	23		Information technology control environment
Energy				
	2003–04	10		Oil sands projects approvals—incorporating risk into project assessment
	2004–05	28	2005–06: 27	Assurance on well and production data
	2006–07	9		Energy's royalty review systems: Royalty regime objectives and targets
	2006–07	10		Energy's royalty review systems: Planning, coverage, and internal reporting

Auditee	Original Report Year	Original Rec.	Repeated	Recommendation subject
	2006–07	11		Energy's royalty review systems: Improving annual performance measures
	2006–07	12		Energy's royalty review systems: Periodic public information
	2006–07	13		Energy's royalty review systems: Enhancing controls
Alberta Energy and Utilities Board	2004–05	29		Assurance systems for volumetric accuracy
Alberta Energy and Utilities Board	2004–05	30		Liability Management for Suspension, Abandonment and Reclamation Activities
Alberta Energy and Utilities Board	2006–07	24		IT control framework
Also see Recommendations to more than one ministry—page 230				
Environment				
	1998–99	30	2000–01: 8 2004–05: 31	Financial security for land disturbances
	2002–03	12	2005–06: 29	Contaminated sites information systems
	2003–04	13		Managing for results: Relevancy and sufficiency of performance measures
	2005–06	1		Drinking Water: Approvals and registrations
	2005–06	2		Drinking Water: Inspection system
	2005–06	3		Drinking Water: Waterworks operators
	2005–06	4		Drinking Water: Information systems
	2005–06	5		Drinking Water: Supporting Environment's drinking water goals
	2005–06	Vol. 1, p. 48		Drinking Water: Communicating with partners
	2005–06	28		Water Well Drilling
Also see Recommendations to more than one ministry—page 230				
Executive Council				
See Cross-Ministry—page 221				
Finance and Enterprise				
	2005–06	30a		Supplementary Retirement Plans—assess the annual and cumulative costs and risks
	2006–07	Vol. 2, p. 85		Alberta Indian Tax Exemption program limits
	2006–07	Vol. 2, p. 86		Journal entries
	2006–07	Vol. 2, p. 87		Obtaining assurance on third party service providers
	2006–07	p. 142		The Government's revenue forecasting systems: Rates of return used to forecast investment income
	2006–07	p. 143		The Government's revenue forecasting systems: Personal income tax forecast
	2006–07	14		The Government's revenue forecasting systems: Corporate income tax forecast

Auditee	Original Report Year	Original Rec.	Repeated	Recommendation subject
	2006–07	15		The Government's revenue forecasting systems: Estimating corporate income tax refunds
	2006–07	16		The Government's revenue forecasting systems: Public reporting of revenue forecasts
Alberta Investment Management	2006–07	25		Controls over derivative contracts
Alberta Investment Management	2006–07	Vol. 2, p. 92		Controls over private investments
Alberta Investment Management	2006–07	Vol. 2, p. 93		Access and change management controls
Alberta Securities Commission	2004–05	p. 198		Hosting and working sessions policies
ATB	1999–00	49	2000–01: 49 2001–02: 17 2003–04: 18 2004–05: 33	Strengthening internal controls—branch operations
ATB	2001–02	16	2002–03: 16	Risk management
ATB	2002–03	15	2003–04: 17 2004–05: 32	Lending policy compliance
ATB	2006–07	26		Processes to confirm compliance with Alberta Finance Guideline
ATB	2006–07	Vol. 2, p. 97		Information technology control framework
ATB	2006–07	Vol. 2, p. 99		General loan loss allowance
Health and Wellness				
	1997–98	27	1999–00: 21 2005–06: 19	Population–based funding: Data improvement
	1998–99	19	1999–00: 39	Academic Health: Governance and accountability
	1998–99	40	2003–04: 21	Heath care registration
	2000–01	17	2005–06: 33	Analysis of physician billing information
	2001–02	24	2003–04: 22 2005–06: 34	Information technology control environment
	2001–02	p. 134	2002–03: 22	Control of, and accountability for, restricted funding
	2002–03	23, p. 156 and 157		Province Wide Services
	2003–04	23		Accountability of the Health Regions to the Minister of Health and Wellness
	2005–06	17		RHA Global Funding: Defining goals and performance measures
	2005–06	18		RHA Global Funding: Non-formula funding adjustments
	2005–06	20		RHA Global Funding: Funding communications
	2005–06	21		RHA Global Funding: Coordination of capital and operating decisions

Auditee	Original Report Year	Original Rec.	Repeated	Recommendation subject
	2005–06	Vol. 1, p. 147		RHA Global Funding: Periodic analysis
	2005–06	Vol. 1, p. 158		RHA Global Funding: Documentation retention
	2005–06	Vol. 1, p. 159		RHA Global Funding: Data availability and timeliness
	2005–06	Vol. 1, p. 160		RHA Global Funding: Resolving Global Funding issues
	2005–06	31		2005 Ministry annual report—results analysis
	2005–06	32		2005 Ministry annual report—performance measures
	2006–07	Vol. 2, p. 105		Unauthorized network connections
	2006–07	27		Outsourced environment
	2006–07	Vol. 2, p. 107		Claims assessment system
Alberta Alcohol and Drug Abuse Commission	Nov. 2006	N.1		Contracting Practices: Internal controls
Alberta Alcohol and Drug Abuse Commission	Nov. 2006	N.2		Contracting Practices: Academic credentials and criminal records checks
Alberta Alcohol and Drug Abuse Commission	Nov. 2006	N.3		Contracting Practices: Board governance
Alberta Alcohol and Drug Abuse Commission	2006–07	Vol. 2, p. 116		General computer controls
Alberta Cancer Board	2001–02	25		Alberta Cancer Board (improve systems for managing cancer drug programs)
Alberta Cancer Board	2006–07	Vol. 2, p. 115		Controls over access to computer applications
Capital Health	2005–06	35		Accurate financial information
Capital Health	2006–07	Vol. 2, p. 110		Business processes
Capital Health Authority and Calgary Health Region	2000–01	p. 135		Performance measures for surgical services
Calgary Health Region	2005–06	36		Monitoring service provider compliance and performance
Calgary Health Region	2006–07	28		Change-management process
Calgary Health Region	2006–07	29		Inappropriate user access
Calgary Health Region	2006–07	30		Contracting for consulting services
Also see Recommendations to more than one ministry—page 230				
Housing and Urban Affairs				
Alberta Social Housing Corporation	Oct. 2005	ASHC 1		ASHC Land Sales Systems—Oct. 2005: Planning for land sales and development in Fort McMurray
Alberta Social Housing Corporation	Oct. 2005	ASHC 2		ASHC Land Sales Systems—Oct. 2005: The Corporation's systems for selling land
Alberta Social Housing Corporation	2006–07	Vol. 2, p 137		Capitalization policy

Auditee	Original Report Year	Original Rec.	Repeated	Recommendation subject
International and Intergovernmental Relations				
	2005–06	Vol. 2, p 58		Agreements for locally engaged staff
Justice and Attorney General				
	2006–07	31		Information Technology Security
	2006–07	Vol. 2, p 129		Disaster Recovery Plans
	2006–07	Vol. 2, p 130		Information Technology Access Controls
	2006–07	Vol. 2, p 131		Judicial Information Technology Security
Municipal Affairs				
	2001–02	46		Emergency preparedness
	2003–04	p. 265	2006–07: Vol. 2, p. 138	Information Technology management controls
Seniors and Community Supports				
	2006–07	Vol. 2, p 143		General computer controls
Department and PDD community boards	2003–04	8		Service provider risk assessment
Department and PDD community boards	2003–04	9		Contract monitoring and evaluation
Also see Recommendations to more than one ministry—page 230				
Service Alberta				
	2001–02	22	2002–03: 20 2004–05: 37	Performance measures
	2003–04	20		Contracting policies and procedures
	2004–05	34		IT project management of Registry Renewal Initiative
	2005–06	37		Physical security
	2005–06	Vol. 2, p. 165	2006–07: Vol. 2, p. 148	Security administration for shared services at distributed sites
	2006–07	32		Service level agreements between Service Alberta and its client ministries
	2006–07	Vol. 2, p 149		Risk assessment for central data centre assets
Also see Cross-Ministry—page 221				

Auditee	Original Report Year	Original Rec.	Repeated	Recommendation subject
Solicitor General and Ministry of Public Security				
	1997–98	34	2002–03: 40	Policing standards
	2006–07	Vol. 2, p 154		Change Management
	2006–07	Vol. 2, p 155		IT Business Continuity Plan
Alberta Gaming and Liquor Commission	2002–03	p. 131		Contract management systems—Contracting processes
Sustainable Resource Development				
	2002–03	p. 277		Contracting
	2005–06	13		Reforestation: Performance information.
	2005–06	14		Reforestation: Performance information
	2005–06	15		Reforestation: Monitoring and enforcement
	2005–06	16		Reforestation: Forest Resource Improvement Association of Alberta
	2005–06	Vol. 1, p 129		Reforestation: Seed inventory
	2006–07	Vol. 2, p 161		Leases and sales
	2006–07	Vol. 2, p 162		Land sale agreements clearly outline the terms and conditions of sales and conditions in land sale and lease agreements are met
	2006–07	33		Requests for proposals to ensure the province gets the best possible value that can be obtained given government objectives
	2006–07	Vol. 2, p 165		Project management
Natural Resources Conservation Board	2003–04	28	2006–07: 34	Natural Resources Conservation Board—Rank compliance and enforcement activities based on risk (Confined feeding operations)
Also see Recommendations to more than one ministry—page 230				
Tourism, Parks and Recreation				
	2006–07	Vol. 2, p 172		Computer control environment
Culture and Community Spirit				
	2004–05	p. 203		Awareness of grant programs available (and guidelines for assessing Other Initiatives Program grants)
	2004–05	p. 205		Review of accounting (Timeliness of grant monitoring)
Wild Rose Foundation	2004–05	p. 142		Wild Rose Foundation's systems for the International Development Program

Auditee	Original Report Year	Original Rec.	Repeated	Recommendation subject
Transportation				
	2003–04	29		Monitoring processes for commercial vehicle and motor vehicle inspection
	2003–04	30		Licensing of commercial vehicle and motor vehicle inspection facilities and technicians
	Nov. 2006	N.5		Infrastructure and Transportation: Capital grants to Métis Settlements
	2006–07	Vol. 2, p. 120		Highway transfers
Treasury Board				
	1996–97	25	1997–98: 41 1998–99: 47 1999–00: 42 2000–01: 45 2001–02: 15 2002–03: 2	Corporate government accounting policies
	2006–07	1		Assessing and prioritizing Alberta's infrastructure needs: Roles and responsibilities need to be better defined and understood
	2006–07	2		Assessing and prioritizing Alberta's infrastructure needs: Capital Plan needs to reduce deferred maintenance and consider life-cycle costs
	2006–07	3		Assessing and prioritizing Alberta's infrastructure needs: Capital Plan needs to reduce deferred maintenance and consider life-cycle costs
	2006–07	4		Assessing and prioritizing Alberta's infrastructure needs: Process to prioritize individual infrastructure projects needs improving
	2006–07	5		Assessing and prioritizing Alberta's infrastructure needs: Process to prioritize individual infrastructure projects needs improving
	2006–07	Vol. 2, p 178		Inconsistent budgeting and accounting for grants
Also see Cross-Ministry—page 221				
Offices of the Legislative Assembly				
	2006–07	Vol. 2, p 189		Strengthen policies for Members' Services Allowance
	2006–07	Vol. 2, p 192		Temporary Residence Allowance

Auditee	Original Report Year	Original Rec.	Repeated	Recommendation subject
Recommendations to more than one ministry				
Food Safety				
Regional Health Authorities	2005–06	6		Food Safety: RHA food establishment inspection programs
Regional Health Authorities and Health and Wellness	2005–06	Vol. 1, p. 83		Food Safety: Tools to promote and enforce food safety
Regional Health Authorities (supported by Health and Wellness	2005–06	7		Food Safety: RHA food safety information systems
Regional Health Authorities	2005–06	8		Food Safety: Compliance with permitting legislation
Agriculture and Food	2005–06	9		Food Safety: Alberta Agriculture's surveillance program
Agriculture and Food	2005–06	10		Food Safety: Alberta Agriculture's inspection and investigation programs
Agriculture and Food	2005–06	Vol. 1, p. 94		Food Safety: Alberta Agriculture's food safety information systems
Health and Wellness and Agriculture and Food (in cooperation with RHAs)	2005–06	11		Food Safety: Integrated food safety planning and activities
Regional Health Authorities, Health and Wellness, and Agriculture and Food	2005–06	Vol. 1. P. 102		Food Safety: Eliminating gaps in coverage
Health and Wellness, and Agriculture and Food	2005–06	12		Food Safety: Accountability
Seniors Care and Programs				
Health and Wellness and RHAs (working with Seniors and Community Supports)	2004–05	6		Seniors Care and Programs, No. 2—page 31: Compliance with Basic Service Standards
Health and Wellness and RHAs (working with Seniors and Community Supports)	2004–05	7		Seniors Care and Programs, No. 3—page 34: Effectiveness of services in long-term care facilities
Health and Wellness (working with RHAs with Seniors and Community Supports)	2004–05	8		Seniors Care and Programs, No. 4—page 35: Effectiveness of services in long–term care facilities
Health and Wellness (working with RHAs with Seniors and Community Supports)	2004–05	p. 61		Seniors Care and Programs—page 37: Information to monitor compliance with legislation
Health and Wellness (working with RHAs with Seniors and Community Supports)	2004–05	9		Seniors Care and Programs, No. 5—page 39: Determining future needs for services in long-term care facilities

Auditee	Original Report Year	Original Rec.	Repeated	Recommendation subject
Health and Wellness	2004–05	p. 62		Seniors Care and Programs—page 39: Report on progress implementing Continuing Care Strategic Service Plans
Seniors and Community Supports	2004–05	12		Seniors Care and Programs, No. 8: Effectiveness of Seniors Lodge Program
Seniors and Community Supports	2004–05	p. 67		Seniors Care and Programs—page 50: Determining future needs
Seniors and Community Supports	2004–05	p. 68		Seniors Care and Programs—page 55: Effectiveness of the Alberta Seniors Benefit Program
Seniors and Community Supports	2004–05	13		Seniors Care and Programs, No. 9—page 56: Information to determine program benefits
Sustainable Resource and Environmental Management (SREM)				
Energy, Environment and Sustainable Resource Development	2004–05	14		Sustainable Resource and Environmental Management (SREM) Implementation Plan

Reporting the status of recommendations

We require the government to agree to an implementation date for each recommendation it accepts. Typically, we do not report on the progress of an outstanding recommendation until management has had sufficient time to implement the recommendation and we have completed our follow-up audit work.

Status of recommendation	**What we say in the report**
Implemented	We briefly explain how the government implemented the recommendation.
Recommendation repeated	We explain why we are repeating the recommendation and what the government must still do to implement the recommendation.
Progress report	We provide information when we consider it useful for MLAs to understand management's actions.

Additional information

Additional information

Standards for systems audits
Systems audits are conducted in accordance with the assurance and value-for-money auditing standards established by the Canadian Institute of Chartered Accountants.

Compliance with the law
We are satisfied that the transactions and activities we examined in financial-statement audits complied with relevant legislative requirements. As auditors, we test only some transactions and activities, so we caution readers that it would be inappropriate to conclude that our testing would identify all transactions and activities that do not comply with the law.

Reference

Glossary

This glossary explains key accounting terms and concepts in this report.

Accountability	Responsibility for the consequences of actions. In this report, *accountability* requires ministries, departments and other entities to: • report their results (what they spent and what they achieved) and compare them to their goals • explain any differences between their goals and results Government accountability allows Albertans to decide whether the government is doing a good job. They can compare the costs and benefits of government action: what it spends, what it tries to do (goals), and what it actually does (results).
Accrual basis of accounting	A way of recording financial transactions that puts revenues and expenses in the period when they are earned and incurred.
Adverse auditor's opinion	An auditor's opinion that financial statements are not presented fairly and are not reliable.
Amortize	To reduce an amount of money to zero over a certain time.
Assurance	An auditor's written conclusion about something audited. Absolute assurance is impossible because of several factors, including the nature of judgment and testing, the inherent limitations of control, and the fact that much of the evidence available to an auditor is only persuasive, not conclusive.
Attest work, attest audit	Work an auditor does to express an opinion on the reliability of financial statements.
Audit	An auditor's examination and verification of evidence to determine the reliability of financial information, to evaluate compliance with laws, or to report on the adequacy of management systems, controls and practices.
Auditor	A person who examines systems and financial information.
Auditor's opinion	An auditor's written opinion on whether things audited meet the criteria that apply to them.
Auditor's report	An auditor's written communication on the results of an audit.
Business cases	An assessment a project's financial, social and economic impacts. A business case is a proposal that analyses the costs, benefits and risks associated with the proposed investment, including reasonable alternatives. The province has issued business case usage guidelines and a business case template that the Department can refer to in establishing its business case policy.
Capital asset	A long-term asset.
Capital planning	A process to: • identify the short- and long-term capital assets needed to carry out core businesses • rank capital projects • prepare business cases to support capital projects • determine the cost and method of financing capital projects

CobiT	Abbreviation for "Control Objectives for Information and Related Technology". CobiT was developed by the Information Systems Audit and Control Foundation and the IT Governance Institute. CobiT provides good practices for managing IT processes to meet the needs of enterprise management. It bridges the gaps between business risks, technical issues, control needs, and performance measurement requirements.
Criteria	Reasonable and attainable standards of performance that auditors use to assess systems.
Cross-ministry	The section of this report covering systems and problems that affect several ministries or the whole government.
Deferred maintenance	Any maintenance work not performed when it should be. Maintenance work should be performed when necessary to ensure capital assets provide acceptable service over their expected lives.
Domain	A logical grouping of computers and devices on a network.
Exception	Something that does not meet the criteria it should meet—see "Auditor's opinion".
Expense	The cost of a thing over a specific time.
GAAP	Abbreviation for "generally accepted accounting principles", which are established by the Canadian Institute of Chartered Accountants.
Governance	A process and structure that brings together capable people and relevant information to achieve goals. Governance defines an organization's accountability systems and ensures the effective use of public resources.
Internal audit	A group of auditors within a ministry (or an organization) that assesses and reports on the adequacy of the ministry's internal controls. The group reports its findings directly to the deputy minister. Internal auditors need an unrestricted scope to examine business strategies; internal control systems; compliance with policies, procedures, and legislation; economical and efficient use of resources; and the effectiveness of operations.
Internal control	A system designed to provide reasonable assurance that an organization will achieve its goals. Management is responsible for an effective internal control system in an organization, and the organization's governing body should ensure that the control system operates as intended. A control system is effective when the governing body and management have reasonable assurance that: • they understand the effectiveness and efficiency of operations • internal and external reporting is reliable • the organization is complying with laws, regulations, and internal policies
Management letter	Our letter to the management of an entity that we have audited. In the letter, we explain: 1. our work 2. our findings 3. our recommendation of what the entity should improve and how it should do so 4. the risks if the entity does not implement the recommendation We also ask the entity to explain specifically how and when it will implement the recommendation.

Outcomes	The results an organization tries to achieve based on its goals.
Performance measure	Indicator of progress in achieving a goal.
Performance reporting	Reporting on financial and non-financial performance compared to plans.
Qualified auditor's opinion	An auditor's opinion that things audited meet the criteria that apply to them, except for one or more specific areas—which cause the qualification.
Recommendation	A solution we—the Office of the Auditor General of Alberta—propose to improve the use of public resources or to improve performance reporting to Albertans.
Risk	Anything that impairs an organization's ability to achieve its goals.
Risk management	Identifying and then minimizing or eliminating risk and its effects.
Server	Computer hardware and software that provides specialized services such as data storage, data processing or web hosting.
Sole-source contract	An agreement with just one supplier chosen without a competitive bidding process.
Systems (management)	A set of interrelated management control processes designed to achieve goals economically and efficiently.
Systems (accounting)	A set of interrelated accounting control processes for revenue, spending, the preservation or use of assets, and the determination of liabilities.
Systems audit	To help improve the use of public resources, we audit and recommend improvements to systems designed to ensure value for money.

Paragraphs (d) and (e) of subsection 19(2) of the *Auditor General Act* require us to report every case in which we observe that:

- an accounting system or management control system, including those designed to ensure economy and efficiency, was not in existence, or was inadequate or not complied with, or
- appropriate and reasonable procedures to measure and report on the effectiveness of programs were not established or complied with.

To meet this requirement, we do *systems audits*. First, we develop criteria (the standards) that a system or procedure should meet. We always discuss our proposed criteria with management and try to gain their agreement to them. Then we do our work to gather audit evidence.

Next, we match our evidence to the criteria. If the audit evidence matches all the criteria, we conclude the system or procedure is operating properly. But if the evidence doesn't match all the criteria, we have an audit finding that leads us to recommend what the ministry must do to ensure that the system or procedure will meet all the criteria.

For example, if we have 5 criteria and a system meets 3 of them, the 2 unmet criteria lead to the recommendation.

A *systems audit* should not be confused with assessing systems with a view to relying on them in an audit of financial statements.

Unqualified auditor's opinion	An auditor's opinion that things audited meet the criteria that apply to them.
Value for money	The concept underlying a systems audit is *value for money*. It is the "bottom line" for the public sector, analogous to profit in the private sector. The greater the value added by a government program, the more effective it is. The fewer resources that are used to create that value, the more economical or efficient the program is. "Value" in this context means the impact that the program is intended to achieve or promote on conditions such as public health, highway safety, crime, or farm incomes. To help improve the use of public resources, we audit and recommend improvements to systems designed to ensure value for money.

Other resources

The Canadian Institute of Chartered Accountants (CICA) produces a useful book called, *Terminology for Accountants*. They can be contacted at CICA, 277 Wellington Street West, Toronto, Ontario, Canada M5V 3H2 or www.cica.ca.

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